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HIV HEALTH SERVICES PLANNING COUNCIL

January 25, 1999 4:30 - 7:30 PM

Room 201 - City Hall - 1 Dr. Carlton B. Goodlett Place

SF H22 #1 1/25/99

1st Posted 1/20/99

Agenda

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I.	Call to Order	4:30 PM
II.	Roll Call	4:35 PM
III.	Review and Approval of Agenda	4:40 PM
IV.	Review and Approval of Minutes from 11/16 and 11/23 - VOTE	4:45 PM
V.	General Announcements	4:50 PM
VI.	Public Comment	4:55 PM
VII.	Mayor's Liaison Report - Bill Barnes	5:00 PM
VIII.	Selection of Joint State HIV Planning Representative - VOTE	5:10 PM
IX.	Committee Reports	
	A. Steering Committee - Proposal for CBC funds - VOTE	5:20 PM
	B. PWA Caucus - By-Laws Revision - VOTE	5:30 PM
	C. Evaluation and Implementation Committee	5:45 PM
	D. BREAK (Food will arrive during the break)	6:00 PM
	E. Needs Assessment Task Force	6:10 PM
	F. Grantee Assessment Task Force	6:25 PM
	G. Membership Committee - Attendance Review - VOTE	6:35 PM
X.	Fair Political Practices Commission Forms	6:50 PM
XI.	Proposal for Unexpended/Unallocated Funds	6:55 PM
XII.	Sandy Schwartz - Survival Times Study Presentation	7:15 PM
XIII.	New Business	7:25 PM
XIV.	Adjourn	7:30 PM

Future Meetings:

Monday, February 1, 1999 - **Evaluation and Implementation Committee**, 25 Van Ness Ave., 5:00 - 7:00 PM
Wednesday February 3, 1999 - **PWA Caucus**, 25 Van Ness Ave., 5:00 PM - 7:00 PM
Thursday, February 4, 1999 - **Membership Committee**, 25 Van Ness Ave., 11:00 AM - 1:00 PM
Monday, February 8, 1999 - **Grantee Assessment Task Force**, 25 Van Ness Ave., 4PM - 5 PM
Monday, February 8, 1999 - **Steering Committee**, 25 Van Ness Ave., 5 PM - 7 PM
Monday, February 22, 1999 - **Planning Council,** City Hall, Room 201, 4:30 PM - 7:30 PM

SF Dept. of Public Health – AIDS Office, 25 Van Ness; City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

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January mailing

- Council agenda for January 25, 1999.
- Council minutes for November 16, and 23, 1998.
- *Draft* job description for Title I Representative to Joint State HIV Planning Working Group.
- Steering Committee Proposal for use of CBC Title I Funds; FY 1999-00 CARE Title I award for the San Francisco EMA; HRSA conditions of eligibility for CBC award; FY '99 CBC Grant Amounts; CBC HIV/AIDS FY 1999 L-HHS-ED Appropriations Conference report package.
- PWA Caucus Proposed Amendment to the Council Bylaws of 11/4/98.
- PWA Caucus Report of 1/15/99; PWA Caucus agenda for 2/3/99; Derek Silva Community memo of 1/4/99 regarding utility rebate and apartment weatherization; PWA Caucus Position Statnment of 5/18/98 on the provision of heat in residential housing CARE contracts; Derek Silva Community *draft* heat and furnace policy and procedure of 1/6/99.
- HIV Consumer Rights Advocate reports for November/December, 1998, and January, 1999.
- Grantee Assessment Task Force report of 12/4/98.
- Membership Committe report of 1/7/99; Membership update from Laura Thomas of 1/7/99; Council demographics chart of 1/6/99.
- Council membership nomination form for 1999.
- Council bylaws attachment A: Process for the Nomination and Appointment of New Members and Althernates.
- Proposal for Allocation of 1999-00 CARE Title I Funds of1/14/99.
- The Impact of Protease Inhibitors and Other Antiretroviral Treatments on AIDS Survival in San Francisco, 1987-1996.

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I. **Call to order**
4:45 PM.

II. **Roll Call**
06-28-99P04:18 RCVD
Attachment A, column 1.

III. **Review and Approval of Agenda**
TC announced that Sandy Schwarcz would not make her scheduled presentation to the Council (agenda item XII).

IV. **Review and Approval of Minutes**
The 11/16/98 minutes were approved, *DB* abstained.
The 11/23/98 minutes were approved.

V. **General Announcements**

- *LO'C* announced a memorial gathering for Mariam Farooq to be held Wednesday, January 27, 1999, from 6:00 to 9:00 PM, at Walden House, 815 Buena Vista West, SF. She also announced a peer education program for people who are HIV positive, starting in February, in the city of San Mateo, the phone number is 650-364-6563.
- *BC* announced that the Coalition of Homeless is making a presentation to the SF Health Commission on February 2, 1999 at 4:00 PM in support of treatment-on-demand.
- SJ thanked *Bill Barnes* for securing a conference room in City Hall for Council meetings.
- *NR* announced the appointment of *Michael Moors* as the Council's Staff Coordinator.
- *Laura Thomas* distributed (1) Governor Davis' proposed FY 1999-2000 state budget with potential impact on HIV/AIDS, produced by the SF AIDS Foundation; (2) the Health Resources and Services Administration (HRSA) December '98 newsletter that features women and HIV/AIDS; (3) a sign-up sheet for information on AIDS testing and guidelines for TB. She announced the Title II award for the three county Eligible Metropolitan area (EMA) which was $1,380,045. This is an increase of about $80,000 over last year. The breakdown was Marin - $121,365, San Francisco - $1,138,692, San Mateo - $119,998.
- *NN* distributed a flyer announcing a new return-to-work program for people with AIDS from the SF Dept. of Public Health (DPH).

VI. **Public Comment**

- *Billy Pick*, Program Manager, HIV Health Services announced his appointment to the Joint State HIV Planning Working Group as a representative of the SFDPH.

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- *Paul Causey*, Executive Director, Tenderloin AIDS Resource Center (TARC), addressing an item brought up at the Dec. Council meeting, said that the on-site psych consult services at TARC are being well used, with appointments booked two to three weeks in advance. He said the backlog for psych consult services at SF General Hospital was a serious problem and suggested the Council consider that as an area for unexpended funds. He also said the integrated service proposal did not include any substance abuse counseling which is an important component for services offered in the Tenderloin.

VII. **Mayor's Liaison Report**

Bill Barnes, Mayor's AIDS Policy Advisor, distributed a room evaluation form. He said the mayor has agreed to meet with the Council's Steering Committee to discuss appointments to the Council. A date has not been set. He said there were some concerns about the Bylaws-Attachment A: Process for the Nomination and Appointment of New Members and Alternates, that he would bring up during the Membership Committee Report. He mentioned the public service announcements introducing the work re-entry program of the SFDPH. The hot-line number for this program is 252-3060. He said re-authorization of the Ryan White Care Act is coming up and encouraged members of the Council to participate in discussions with the Mayor's Office and the SFDPH. He said the Mayor sent a letter to Representative Pelosi regarding the importance of the "hold harmless" clause. He distributed (1) a letter from eight mayors to Dr. John Palenicek, Dir., Office of Policy & Program Development, HRSA, stating their opposition to the proposed housing guidance, and (2) a letter to President Clinton stressing the disproportionate impact of HIV/AIDS on gay and bisexual men, and the transgender community. He suggested the Council consider an assessment of the overall delivery system of CARE funded programs as a use for unexpended funds. *TC* asked for clarification why no Council nominees have been appointed by the Mayor since *Bill Barnes*' meeting with the Steering Committee. *Bill Barnes* said he passed on the request to appoint *Laura Carcagno* and *Luis De La Torre* as Council members, and that the Mayor would address those appointments when he returned from the Conference of Mayors next week. *LO* asked if *Bill* could anticipate when the Mayor's meeting with the Steering Committee's would happen. *Bill* said the meeting would be scheduled when as many members of the Steering Committee as possible could make it, and the appointments of new members would happen as soon as possible. He introduced *Bill Bourdon*, Special Assistant to the Mayor, who will be working with the AIDS Policy Advisor.

VIII. **Selection of Joint State HIV Planning Representative** - VOTE

MJW said the State has combined the Prevention Planning group and the CARE Planning group into a joint group. There will be one representative of Northern California EMAs and one of Southern. The terms will be two years with Northern and Southern representatives elected on alternate years.

MJW distributed a job description for a Title I Representative to a joint Northern and Southern California HIV planning working group. The representative will be responsible for coordinating information from the five Northern California EMAs and reporting back to them after the joint meeting. *SO* asked the size of the group and who makes up the membership. *MJW* said there are 50 members with over half of them consumers. There are providers as well as mandated seats, such as a MEDI-CAL representative. *MJW* is willing to serve on the newly formed group. *LO* asked what the make-up of the group would be in terms of CARE and Prevention members. *MJW* said it would be about 50% from each group. *KW* suggested a follow-up report on the group after it meets.

- *TC* called for a voice vote "*to appoint MJW as Title I Representative to the Joint State HIV Planning Working Group.*"

The motion passed unanimously by voice vote.

IX. **Committee Reports**

A. Steering Committee - Proposal for CBC funds - VOTE
   - *TC* presented "*the Steering Committee proposal for use of CBC Title I Funds to the Council for a vote.*"

   Discussion: *Michelle Dixon* said the due date for information on how the EMA proposes to use the funds has been extended until February 23, 1999. She said the proposal needs to be accessible to people with HIV throughout the three counties of the EMA. The funds are intended to provide better outcomes for African-Americans with HIV. She hopes that links can be made to other forthcoming CBC appropriations. *TC* said a proposal needs to be approved at this meeting to meet HRSA's deadline. *MJW* suggested adding Latinos to the proposal. *Michelle* said the initiative was for African-Americans only but that consideration

for eligibility for the funds included African Americans and Latinos. She said HRSA is in the process of getting a legal opinion on what the true intent of the legislation is. She said she was given direction to follow the current wording of the initiative until further notice. *KW* said it would be difficult to implement this proposal at San Quentin if Latinos were not included. *SS* asked what criteria were used to arrive at this proposal. *SJ* said the Needs Assessment flagged this as an area of need that could apply to all three counties. *SO* said there were not many things that could be done with this amount of money which confined the discussion. *BC* said the Minority National AIDS Council (MNAC) requested the funds go to African-Americans only. He asked if services in the proposal were to be identified. *TC* said that the intention of the proposal was appropriate services that would be identified during implementation. *VC* was glad to see language directly referring to transgenders in the proposal. *SJ* said that this small amount of money is just a place to start growing services for underserved populations. *LO'C* said some incarcerated people don't feel they have access to services when they come out of prison. *BVB* asked if the proposal would be put out to bid. *Michelle* said they would do a rapid alternate solicitation. *KB* thought the evaluation was vague. *Michelle* said the final form would be more specific. *EW* called the question.

The motion to approve the Steering Committee Proposal for use of CBC Title I Funds passed. [attachment A, column 2]

B. PWA Caucus - Bylaws Revision - VOTE

TL reported that the new Co-Chairs of the PWA Caucus are *VC, TL,* and *LO'C. LO'C* said there continues to be a problem with heat at Derek Silva Community and felt a request from the Acting Program Director concerning an Energy Assistance Program rebate was inappropriate. *TC* asked if the HIV Consumer Rights Advocate is working on the heating issue. *TL* said that she is. *VC* announced that there were several upcoming community forums, but that no dates have been set at this time. *TC* said that the PWA Caucus will work with consultants from the Needs Assessment.

- *TL* presented "*a proposed amendment to the Council Bylaws that would add a new section stating the purpose and defining the duties of the PWA Caucus to the Council for a vote.*"

The motion passed. [attachment A, column 3]

MJW asked that the HIV Consumer Rights Advocate Reports be dated correctly.

C. Evaluation and Implementation Committee

AR reported that the Committee discussed Implementation for both 1998-99 and 1999-00. She announced that *FC* has resigned from the Council and that there will be an election at the next Committee meeting to fill the vacant Co-Chair position.

D. Needs Assessment Task Force

EW reported that the Task Force sent out a Request for Proposals (RFP). They met to evaluate the three proposals they received, and have chosen a joint proposal from Harder & Co. and the Support Center for Nonprofit Management. He said surveys will be developed over the next several weeks, all three counties will be covered, and they are looking for people to help with the assessment. Interested Council members should contact *AR.*

E. Grantee Assessment Task Force

AM reported that the CARE Act states the EMA has a responsibility to check dispersment of funds and determine how effective grantee programs are. The Task Force is hoping to send out a solicitation and have responses by next month. *TC* encouraged Council members to get involved in this Task Force.

G. Membership Committee - Attendance Review - VOTE

- *BVB* submitted "*the application of Dr. Samuel Kaplan, as the State Medicaid Representative, to the Council for a vote of recommendation to the Mayor.*"

The recommendation passed by voice vote.

BVB reported that, based on information provided by *Laura Thomas* in her Membership Update memo, the Committee will focus its outreach efforts on HIV-positive members of the Latino and African-American Communities. Members were encouraged to distribute 1999 membership nomination forms to potential candidates. The Committee is reviewing attendance records for the last two quarters of 1998 (July-September, October-December) and requested Committee Co-Chairs with attendance records, or minutes from Committee meetings, to contact *LO* or *BVB.* The Committee found *LM* out of compliance with the bylaw requirements of attendance and sent her a letter stating the Committee's intent to recommend

she be dismissed from the Council. *BVB* presented a motion "to forward a letter to the Mayor's Office stating *Leann Monfredini*, based on failure to meet minimum attendance requirements, be dismissed from the Council." *KW* asked if the letter sent to *LM* gave her a chance to comment. *BVB* said that it did and that she had been contacted by phone as well. *LO* said he spoke with *LM* and said she was aware of her absence but there is a conflict in her schedule for Monday evenings. *BVB* said the letter to the Mayor will acknowledge her experience and expertise as President of the Health Commission. *SJ* called the question. *DCB* thought the Council had the authority to dismiss members itself. *TC* stated that Article VI Sec. 3 of the Council bylaws says "the Council member shall be terminated by the Mayor upon recommendation of the Council, and upon recommendation of the Membership Committee, the Mayor shall re-appoint a new Council member to fill the vacancy." *SO* asked that the motion be restated.

- *BVB* said the motion before the Council was "*to approve a letter to the Mayor, from the Membership Committee, recommending that Leann Monfredini be dismissed from the Council based on failure to meet minimum attendance requirements.*"

The motion passed. [attachment A, column 4]

BVB noted that several Council members just met the minimum attendance requirement, which is not the same as meeting the standard of the Council. The next Committee meeting, on February 4, 1999, will review the termination section of the bylaws to bring that language into agreement with the new Council schedule. He also stated that he is considering resigning from the Council to go back to school and encouraged anyone interested in replacing him as Co-Chair of the Membership Committee to attend the next meeting.

Discussion: *TC* and *AR* attended the last meeting of the Housing Opportunities for People With AIDS (HOPWA) Loan Committee. Four projects were approved with revisions. They discussed the augmentation of the budget for the Consumer Rights Advocate program to allow HOPWA funded projects to be eligible for that service. *NN* said that when votes are listed on the agenda they need to be described in more detail. *KW* pointed out that Committee meetings held in the evening are a problem for people with childcare issues. *EW* noted that the next Needs Assessment Task Force meeting would be Monday, February 1, 1999, at 25 Van Ness Ave., from 4:00 to 5:00 PM. *LO'C* said that the Consumer Rights Advocate reports will be more accurate in future.

X. **Fair Political Practices Commission Forms**

Laura Thomas distributed (1) a memo explaining the purpose of the Fair Political Practices Commission (FPPC) Statement of Economic Interests, Form 700; (2) a sample cover page of the form; (3) Form 700 1998-99 Statement of Economic Interests. She said the cover page and Schedule C are the portions that need to be filled out. She asked Council members to return completed forms to her by March 1, 1999. *NN* pointed out that Council members also need to fill out a FPPC form when they leave the Council.

XI. **Proposal for Unexpended/Unallocated Funds**

Michelle Dixon reviewed her memo of 1/14/99, regarding the Proposal for Allocation of 1999-00 CARE Title I Funds, and the two attached pages of budgetary items including a combination of proposals for funding FY 1999-00 and close-out for FY 1998-99.

- Proposal for Allocation of 1999-00 CARE Title I Funds: *Michelle* explained that the Grant Award for 1999-00 is less than the 1998-99 Award by $235,369. That shortfall includes the $67,788 mandated for the new CBC Initiative that must come out of existing funding.
- Discontinued Programs by Category - FY 1999-00: Two providers quit their Substance Abuse contracts this year, leaving unallocated funds totaling $344,394 after the subtraction of the shortfall from the 1998-99 Award. In addition, there will be an increase in the Title II Award of about $80,000 leaving a total of approximately $424,000 in unallocated funds.
- The AIDS Office proposed using unallocated funds from 1999-00 for the projected shortfalls in Home Health and other Substance Abuse programs. Those figures are yet to be determined.
- The AIDS Office proposed using unexpended funds from 1998-99 for facility-based care in Home Health and Integrated Care vouchers. The amounts of these funds are yet to be determined, and must be spent by the end of February, 1999.

Discussion: *SJ* suggested the Steering Committee assess the possible use of unallocated funds. *TC* said the Council did not need to make a decision about unallocated funds at this meeting and suggested concentrating the discussion on unexpended funds. *AR* said the Evaluation & Implementation Committee will discuss the use of unallocated funds at their next meeting on Monday, February 1,1999 at 25 Van Ness, 5th floor, from 5:00 to 7:00 PM. Their

recommendations will go to the Steering Committee and then back to the Council for a vote next month. *KW* asked if the AIDS Office will have a better idea of the 1998-99 unexpended amount by the next Steering Committee meeting. *Michelle* said they would. *EW* asked if unexpended funds could be used for the Needs Assessment. *TC* said they can be spent however the Council chooses. *SJ* moved to refer the decision of the use of 1998-99 unexpended funds to the Steering Committee who will consider the 1998-99 prioritization for possible recommendations as to the use of unexpended funds to be made to the AIDS Office. *Michelle* requested that this issue not be last on the Steering Committee agenda. *SO* asked that the motion be restated.

- *TC* said the motion was "*to refer the decision concerning the use of unexpended funds for FY 1998-99 to the Steering Committee, February 8, 1999, and to instruct the Steering Committee to consider the previously determined priorities for use of unexpended funds during the 1998-99 prioritization.*"

The motion passed by voice vote.

XII. **Sandy Schwarcz - Survival Times Study Presentation**
Canceled.

XIII. **New Business**
KB requested that every other roll call be read in reverse alphabetical order when there are multiple roll call votes during a meeting.

XI. **Adjournment**
6:30 PM

The Council meets on the fourth Monday of each month, at the time and place noted on the agenda. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. The closest accessible BART station is Civic Center. Accessible MUNI lines serving this location are: #42 Downtown Loop, #71 Haight/Noriega, #9 San Bruno, F Line to Market and Van Ness, and Metro Van Ness station. For more information about MUNI accessible services, call 923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

1/25/99		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	*KB*	P	Y	Y	Y								
Marianna Balquiedra	*MB*	A											
Dorothy Bartolomucci	*DB*	P	Y	Y	Y								
Donald Bliss	*DCB*	P	Y	N	Y								
Chris Boehm	*CB*	A											
Jeff Byers	*JB*	A											
Virginia Cafaro	*VC*	A											
Tom Calvanese	*TC*	P	Y	Y	Y								
Bart Casimir	*BC*	P	Y	Y	Y								
Veronika Cauley	*VC*	P	Y	Y	Y								
Julie Charubusapayon	*JAC*	A											
John Conley	*JC*	P	Y	Y	Y								
Mark Dunlop	*MD*	P	Y	Y	Y								
Gene Gowdey	*GG*	P	Y	Y	Y								
Siddiq Jihad	*SJ*	P	Y	Y	Y								
Darrell Joe	*DCJ*	P	Y	Y	Y								
Diane Jones	*DJ*	A											
Tony Leone	*TL*	P	Y	Y									
Allen Meyer	*AM*	P	Y	Y									
Leann Monfredini	*LM*	A											
Norm Nickens	*NN*	P	Y	Y	N								
Lisa O'Connor	*LO'C*	P	Y	Y	Y								
Loras Ojeda	*LO*	P	Y	Y	Y								
Jorge Ortiz	*JO*	A											
Stephan Oxendine	*SO*	P	Y	Y	Y								
Alissa Riker	*AR*	P	Y	Y	Y								
Nilda Rodriguez	*NR*	P	Y	Y	Y								
Matthew Sharp	*MS*	A											
Susan Shea	*SS*	P	Y	Y	Y								
Thomas Sinclair	*TS*	A											
Brett VanBenschoten	*BVB*	P	Y	Y	Y								
Kelly Wallace	*KW*	P	Y	Y	Y								
Eric Whitney	*EW*	P	Y	Y	Y								
Mary Jane Wood	*MJW*	P	Y	Y	Y								

HIV HEALTH SERVICES PLANNING COUNCIL

February 22, 1999 4:30 - 7:30 PM

Room 201 - City Hall - 1 Dr. Carlton B. Goodlett Place

Agenda

I.	Call to Order	4:30 PM
II.	Roll Call	4:35 PM
III.	Review and Approval of Agenda	4:40 PM
IV.	Review and Approval of Minutes 12/21/98 & 1/25/99 - **VOTE**	4:45 PM
V.	General Announcements	4:50 PM
VI.	Public Comment	4:55 PM
VII.	Sandy Schwarcz - Survival Times Study Presentation	5:00 PM
VIII.	AIDS Office Report	5:20 PM
IX.	Committee Reports	
	A. Steering Committee • Meeting with Mayor • Unexpended funds	5:30 PM
	B. Break	5:45 PM
	C. Evaluation and Implementation Committee • VOTE - additional Residential Home Health funds • VOTE - authorize Steering Committee to distribute unallocated funds	6:00 PM
	D. Membership Committee - Notice 2 Bylaw changes: • Council structure & Attendance requirement	6:10 PM
	E. HOPWA Loan Committee	6:20 PM
	F. Grantee Assessment Task Force • VOTE - Financing • VOTE - Final decision making	6:30 PM
	G. Needs Assessment Task Force	6:50 PM
	H. PWA Caucus	7:00 PM
X.	Mayor's Liaison Report - Bill Barnes	7:10 PM
XI.	New Business	7:20 PM
XII.	Adjourn	7:30 PM

Future Meetings:

Tuesday, February 23,1999 - **Needs Asessment Task Force**, 25 Van Ness Ave., Rm. 330-B, 5:30-7:30 PM
Wednesday, February 24, 1999 - **Ad Hoc Housing Committee** 25 Van Ness Ave., Location TBD, Noon
Monday, March 1, 1999 - **Needs Assessment Task Force**, 25 Van Ness Ave., Rm. 330-B, 4-6 PM
Monday, March 1, 1999 - **Evaluation & Implementation**, 25 Van Ness Ave., Rm. 330-A, 5-7 PM
Wednesday, March 3, 1999 - **PWA Caucus**, 25 Van Ness Ave., Rm. 330-B, 5-7 PM
Thursday, March 4, 1999 - **Membership Committee**, 25 Van Ness Ave., Rm. 330-B, 11 AM - 1 PM
Monday, March 8, 1999 - **Grantee Assessment Task Force**, 25 Van Ness Ave., 5th flr. Conf. Rm., 4-5 PM
Monday, March 8, 1999 - **Steering Committee**, 25 Van Ness Ave., 5th flr. Conf. Rm., 5-7 PM
Monday, March 22, 1999 - **Planning Council**, City Hall, Room 201, 4:30 - 7:30 PM

SF Dept. of Public Health — AIDS Office, 25 Van Ness, 5th floor
City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

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HIV Health Services Planning Council
Minutes, February 22, 1999

SF
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February mailing
-Council agenda for February 22, 1999.
-Council minutes for December 21, 1998, and January 25, 1999.
-Needs Assessment Task Force Report - 2/1/99.
-Evaluation & Implementation Committee Report - 2/1/99.
-PWA Caucus Report - 2/3/99.
-Membership Committee Report - 2/4/99.
-Grantee Assessment Task Force Report - 2/8/99.
-Steering Committee Report - 2/8/99.
-HIV Consumer Rights Advocacy Project Report - 2/9/99.
-Proposed Bylaws Changes from Membership Committee - 2/10/99.

06-28-99P04:19 RCVD

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JUN 28 1999

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I. **Call to Order** 4:30 PM

II. **Roll Call** [Attachment A, column 1]
CB holding a proxy vote for *Matt Sharp*.

III. **Review and Approval of Agenda** Approved.

IV. **Review and Approval of Minutes**
Minutes for December 21, 1998, approved. Abstentions: *MB, DB, JB, AR.*
Minutes for January 25, 1999, approved. Abstentions: *MB, DB, JB.*

V. **General Announcements**
- *DJ* announced a Save The Date for Bridging the Gap II Conference which is being organized by the Department of Public Health (DPH) with a focus on integrating traditional substance abuse and harm reduction services. [Attachment B] The initial Conference was two years ago for substance abuse providers. Scheduled for May 3 and 4, 1999.
- *VC* announced a transgender activity re: violence rally in the transgender community and thanked several council members for attending.

VI. **Public Comment**
- *John Claude Corey*-PWA who was banned from Project Open Hand expressed his concern re: his being banned for life from the organization and his efforts to fight the organization through meeting with Supervisor Bierman.
- *George Simmons,* Catholic Charities, and *Ken Bukowski,* Positive Resource Center, distributed a brochure re: new subsidy program beginning on March 1. [Attachment C] The program has an emphasis on re-entry to job market. There are 150 subsidies in the program; funded through SF Redevelopment Agency with Housing Opportunities for People With AIDS (HOPWA) funds for 18 months.

VII. **Survival Times Study Presentation**
Sandy Schwarcz presented findings from the Survival Times Study. [Attachment D] They did a survival analysis to look at the impact of treatment on AIDS survival amongst people in San Francisco. Studies show that protease inhibitors are effective, but they are clinical trials. This study used the AIDS registry to avoid selection bias. Goal of study was to measure effect of protease and other antiretrovirals on Survival trends from 1987 to 1996. First part of analysis shows that survival improved. Second part of analysis showed that factors associated with mortality included older age, injection drug use and persons with an opportunistic illness as their initial AIDS diagnosis. Sandy distributed a handout detailing these conclusions. Feedback from council members included concerns re: sampling guidelines.

VIII. **AIDS Office Report**
Laura Thomas presented several announcements:
- The Fair Political Practices Commission Forms for 1998 are due from several council members;
- The Results from Transgender forum will be mailed to Council members;
- The Title II application was sent to the State on time;
- The Congressional Black Caucus Initiative update the Council approved was sent to HRSA;

- Tracy Packer from the Prevention Section of the AIDS office will be sending out letters re: program on secondary prevention. A Community Advisory Board is in the process of forming and will also send out letters to Council members;
- John Chin, graduate student in NYC, did a study on community participation surveys that will be mailed to members;
- Assembly member Carrie Missoni introduced AB518, a new needle exchange bill for this legislative session. The bill would legalize needle exchange programs like the one SF runs and make it possible for people to get needles from pharmacies. Update to come.

IX. **Committee Reports**

A. Steering Committee, *Loras Ojeda*
LO spoke about the Committee's meeting with Mayor Brown re: membership, compliment of Council, and approval of new members, Louis De La Torre and Laura Carcagno. Also spoke about streamlining the nomination process and changing the commitment to 2 years instead of 1 year.

Unexpended funds - FY 1998-99.
Michelle Long Dixon, AIDS Office, presented re: unexpended funds. Michelle explained that the amount of excess funds was changed from $200,000 to $665,296 and said that this must be expended by February 28, 1999, to avoid the perception that the funds are not needed by the Council.
Discussion: Michelle advised that the Council vote re: expending funds to avoid a rollover request. *TL* expressed that it would be injurious to vote without prior notification. Several ideas were proposed, i.e.: taxi vouchers, household goods, ADAP. *TC* advocated for #300,000 to taxi vouchers and remainder to the large pot, VC expressed concern re: applying funds to SF General pharmacy, *LO* asked when the AIDS office was aware of excess funds, Michelle informed that they only knew as of last week, *LC* asked why housing is not considered launched a discussion as to what options the council has to use the funds and flaws in reprioritization process.
TL-Motion to refer the matter to an emergency Steering Committee meeting this week.
Voice vote: 19 for and 6 opposed. Motion approved.

B. Evaluation and Implementation Committee, *Diane Jones*
TC: Vote on Residential Home Health Funds and unallocated funds. Discussion of the differences of unexpended (unspent at end of fiscal year) and unallocated funds (dollars not allocated for a particular purpose in the coming fiscal year.)
MJW made a motion to recommend addition of $103,146 in fiscal year 99/00 for Home Health services in residential sites. Motion approved. [Attachment A, column 2]
Refer decision re: expenditure of unallocated funds to Steering Committee meeting. Motion approved. [Attachment A, column 3]

C. Membership Committee, *Loras Ojeda*
- *Brett Van Benschoten* resigned as co-chair and is expected to resign from the Council.
- *LO* seeking names and asked members to provide applications to prospective members.
- *LC* and *LDLT* have not been formally oriented yet
- Attendance review will be current and up to date by next council meeting.
- Changes in by-laws language- see packet, page 5 re: language about minimal requirements; and page 3, Section 7, article 4.

D. HOPWA Loan Committee, *Alissa Riker*
- Capital Improvement for Maitri Hospice- small amount of funds
- Subsidies through Catholic Charities
- Ambassador Hotel- $2 million in HOPWA funds used
- Housing Ad Hoc Meeting on Wednesday, March 3, 12:00 noon, at 25 Van Ness; will be discussing formula for housing.

E. Grantee Assessment Task Force, *Alan Meyer* (VOTE)
Task force Solicitation for Proposals available February 12, 1999. Letter of Intent (LOI) due March 5,1999, proposal due March 26, 1999,(see Task Force Report). The goal is to identify areas that can be improved and rapid allocation of available funds. They are proposing up to $50,000 be made available to do this.

VOTE: Earlier Motion to refer the decisions re: funding & revised timeline to emergency Steering Committee where that decision should be made. Vote approved re: funding decision and revised timeline April 12, 1999.
Discussion: *JB* expressed concern re: number of items being referred to Steering Committee. *DJ* said all decisions should not be brought to the full Council, particularly decisions re: funds; *TL* shares concern of *JB*. *KB* supports decisions of Steering Committee as it worked well with Needs Assessment Task Force, *MJW* supports Motion for Steering Committee.
Motion to Authorize Steering Committee to make decision re: recommendation of the Grantee Assessment Task Force re: the selection of contractors to conduct the grantee assessments: Voice vote. Motion approved. 1 abstention: *NN*.

F. Needs Assessment Task Force, *Eric Whitney*
The Task force has been meeting every week- recent meeting prioritized stratification of the populations they are meeting with. The contractors recommend sampling with client surveys. The next Task Force meeting, Monday, March 1, 1999, will discuss finalizing client survey and the sampling focus groups: will be having between 20-22 focus groups in SF and San Mateo. Anyone interested, please come to the meetings, or see EW or SJ.

G. PWA Caucus, *Veronica Cauley*
Next Caucus meeting is Wednesday, March 3, 1999, read notes from PWA Caucus for further information. Co-chair, *LO'C* spoke about letter written re: Derek Silva House and LOI requesting individual rebate and submission of check to agency. *LO'C* wrote letter in response; issue is being addressed. *DB* expressed concern about community outreach forums re: scheduling conflicts, lack of organization and lack of representation from the Council.

X. **Mayor's Liaison Report**
Bill Barnes, AIDS Policy Advisor made several announcements:
- He recently had a meeting with Luis De La Torre and Sam Kaplan.
- Each year there is less money for AIDS services. The Council needs to rethink what HIV service delivery is about and tighten prioritization.
- The Mayor's Office is looking for people who are HIV+ to appoint to other commissions, please put out the word. Some positions pay a stipend, some do not, but they allow the voice of PWA's to be heard.

XI. **Adjourn** 8:00 PM

Maureen Fiorelli – minutes.

The Council meets on the fourth Monday of each month, at the time and place noted on the agenda. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. The closest accessible BART station is Civic Center. Accessible MUNI lines serving this location are: #42 Downtown Loop, #71 Haight/Noriega, #9 San Bruno, F Line to Market and Van Ness, and Metro Van Ness station. For more information about MUNI accessible services, call 923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

2/22/99		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	*KB*	P	Y	Y									
Marianna Balquiedra	*MB*	P	Y	Y									
Dorothy Bartolomucci	*DB*	A											
Donald Bliss	*DCB*	P	Y	Y									
Chris Boehm	*CB*	P	Y	Y									
Jeff Byers	*JB*	P	N	Y									
Virginia Cafaro	*VC*	A											
Tom Calvanese	*TC*	P	N	Y									
Bart Casimir	*BC*	P	Y	Y									
Veronika Cauley	*VC*	P	Y	Y									
Julie Charubusapayon	*JAC*	P	Y	Y									
John Conley	*JC*	P	N	Y									
Mark Dunlop	*MD*	A											
Gene Gowdey	*GG*	P	Y	Y									
Siddiq Jihad	*SJ*	P	B	Y									
Darrell Joe	*DCJ*	P	N	Y									
Diane Jones	*DJ*	P	Y	Y									
Tony Leone	*TL*	P	Y	Y									
Allen Meyer	*AM*	P	Y	Y									
Leann Monfredini	*LM*	A											
Norm Nickens	*NN*	P	Y	Y									
Lisa O'Connor	*LO'C*	P	Y	Y									
Loras Ojeda	*LO*	P	N	Y									
Jorge Ortiz	*JO*	P	Y	Y									
Stephan Oxendine	*SO*	P	Y	Y									
Alissa Riker	*AR*	P	Y	Y									
Nilda Rodriguez	*NR*	P	Y	Y									
Matthew Sharp	*MS*	A		Y									
Susan Shea	*SS*	P	Y	Y									
Thomas Sinclair	*TS*	A											
Brett VanBenschoten	*BVB*	A											
Kelly Wallace	*KW*	P	Y	Y									
Eric Whitney	*EW*	P	Y	Y									
Mary Jane Wood	*MJW*	P	Y	Y									

HIV HEALTH SERVICES PLANNING COUNCIL

March 22, 1999 4:30 - 7:30 PM

Room 201 - City Hall - 1 Dr. Carlton B. Goodlett Place

Agenda

I.	Call to Order		4:30 PM
II.	Roll Call		4:35 PM
III.	Review and Approval of Agenda		4:40 PM
IV.	Review and Approval of Minutes from 2/22/99 - VOTE		4:45 PM
V.	General Announcements		4:50 PM
VI.	Public Comment		4:55 PM
VII.	CDC Demonstration Project - Tracey Packer/HIVPrevention		5:05 PM
VIII.	Committee Reports		
	A. Steering Committee		
	• Report on unallocated FY 98-99 & FY 99-00 funds		5:15PM
	• Co-chairs Report - Prioritization/Council structure		5:35 PM
	B. Membership Committee		5:45 PM
	• Bylaws revision - VOTE		
	• Nominations - VOTE		
	• Attendance review - VOTE (?)		
	BREAK (Food)		6:15 PM
	C. Needs Assessment Task Force		6:30 PM
	• Gary Levinson/Support Center		
	D. Evaluation & Implementation Committee		6:50 PM
	E. Grantee Assessment		6:55 PM
	F. PWA Caucus		7:00 PM
	G. Housing Task Force		7:05 PM
IX.	AIDS Office Report - CAER Coalition/reauthorization		7:10 PM
X.	New Business		7:25 PM
XI.	Adjourn		7:30 PM

Future Meetings:

Thursday, April 1, 1999	**Membership Committee**	25 Van Ness Ave.	11:00 AM - 1:00 PM
Friday, April 2, 1999	**Grantee Assessment Task Force**	25 Van Ness Ave.	4:00 PM - 6:00 PM
Monday, April 5, 1999	**Evaluation & Implementation Committee**	25 Van Ness Ave.	5:00 PM - 7:00 PM
Monday, April 5, 1999	**Needs Assessment Task Force**	25 Van Ness Ave.	4:00 PM - 6:00 PM
Wednesday, April 7, 1999	**PWA Caucus**	25 Van Ness Ave.	5:00 PM - 7:00 PM
Friday, April 9, 1999	**Housing Task Force**	25 Van Ness Ave.	12:00 PM - 2:00 PM
Monday, April 12, 1999	**Steering Committee**	25 Van Ness Ave.	5:00 PM - 7:00 PM
Monday, April 12, 1999	**Needs Assessment Task Force**	25 Van Ness Ave.	5:30 PM - 7:30 PM
Monday, April 26, 1999	**Planning Council**	City Hall, Room 201,	4:30 PM - 7:30 PM

SF Dept. of Public Health — AIDS Office, 25 Van Ness, 5th floor
City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

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SF
#22
#2
3/22/99

April mailing
- Council agenda for April 26, 1999.
- Council minutes for March 22, 1999.
- Needs Assessment Task Force reports of 3/17/99, 3/23/99, 4/1/99, 4/5/99,
- Membership Committee report of 4/1/99
- Grantee Assessment Task Force report of 4/2/99
  Recommendation of Consultant 4/9/99
- Evaluation & Implementation Committee report of 4/5/99
- PWA Caucus report of 4/7/99
- Ad Hoc Housing Committee report of 4/9/99
- REGGIE Evaluation Task Force report of 4/12/99
- Steering Committee report of 4/1299

06-28-99P04:19 RCVD

I. **Call to order**
4:35 PM.

II. **Roll Call**
Attachment A, column 1.

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III. **Review and Approval of Agenda**
Agenda approved.

IV. **Review and Approval of Minutes**
Postponed until the Council had a quorum.

V. **General Announcements**
- *SJ* announced a Town Hall Meeting sponsored by The Black Coalition on AIDS, Thursday, March 25, 1999, 6-8 PM, West Bay Conference Center, 1290 Fillmore St., San Francisco.
- *MJW* announced two job openings with the San Mateo County AIDS Program: (1) a Coordinator in the Education and Prevention unit, and (2) a Benefits Counselor for the primary care clinic who speaks Spanish.
- *LO* announced a reception on Thursday, March 26,1999, 5:30 - 6:30 PM, in Polk Hall, at Phil Graham Auditorium sponsored by Mobilization Against AIDS, Global AIDS Program, and the Global Network of People Living with HIV during the update conference.
- *LO'C* announced a march around Lake Merrit in Oakland, Saturday, March 27, 1999, starting at 1:00 PM from the W.O.R.L.D. office to recognize women with HIV.
- *DJ* announced the death of Thomas Sinclair and mentioned some of the contributions he made to the Council.
- *EW* announced two upcoming meetings of the Needs Assessment Task Force that were not included with the Future Meetings listed on the agenda: Tuesday, March 23, and Thursday, April 1, 1999, 5:30 to 7:30 PM, 25 Van Ness Ave., Room 330-B.
- *JO* mentioned that the SF AIDS Foundation has cut funding for its Spanish language newsletter and asked what the Council could do about it.

VI. **Public Comment**
- *John Claude Koury* announced that the staff of the Immune Enhancement Project has established a fund in the name of Thomas Sinclair for emergency care for people who need alternative medicine.
- *Hank Wilson*, Treatment Advocate, Tenderloin AIDS Resource Center (TARC), spoke about the need for a consistent supply of bus tokens at San Francisco agencies like TARC. Clients get used to having emergency tokens available to keep appointments and when tokens are not available it breaks down the momentum clients have established. *MJW* asked if any of these clients were eligible for para-transit? *Hank* said getting on para-transit can be a lengthy process.
- *Dr. Alice Gleckorn*, Community Substance Abuse Services, Dept. of Public Health (DPH), distributed a brochure *Integrating Traditional Substance Abuse and Harm Reduction Services* for the upcoming Bridging the Gap conference, Monday, May 3, 1999, 8:30 AM to 5:00 PM, and Tuesday, May 4, 1999, 9:00 AM to 5:00 PM, at the Radisson Miyako Hotel, 1625 Post St., San Francisco. She passed out a survey asking Council members what subjects they would like

to see included in the workshops. Most workshops will be intensive skills building, and interactive. The conference is free.
- *TC* distributed the Health Resources and Services Administration (HRSA) monthly newsletter HRSA Care*ACTION*. The feature article is titled *HIV/AIDS in Racial and Ethnic Minorities*.

VII. **Center for Disease Control (CDC) demonstration project**

Tracey Packer, HIV Prevention Section, DPH, distributed a statement entitled *Primary Prevention for HIV Positive Individuals Demonstration Project.* It included a summary of the project, the role of the Community Advisory Board (CAD), the timeline, and representation. San Francisco will receive $700,000 for each of the 5 year Project to cover administration as well as service funding. The Project was designed by the HIV Prevention Planning Council (HPPC). The three goals of the Project are: (1) Market HIV testing to high risk individuals; (2) Ensure that people who are HIV positive have access to health care, retroviral treatment, and other services; and (3) Provide primary HIV prevention programs to HIV+ individuals. The three working groups of the CAB will be: (1) The testing Working Group who will assess specific needs and develop methods to increase testing among priority populations. (2) The Referral to Care Working Group who will identify methods for reaching HIV+ people not in care. (3) The Primary Prevention Working Group who will identify appropriate mechanisms to integrate primary prevention into HIV health care. Invitations to be on the CAB will be sent to all Council members. The goal is to have the CAB in operation by July 1999. *LM* asked if this work wasn't already being done by other organizations. *Tracey* said there is testing but not in primary prevention specifically for HIV clients. It's also an opportunity to find gaps in service. There are 5 sites throughout the country involved in this Project. *LO* asked if the desired outcomes will be defined by the CAB or the CDC. *Tracy* said both would be involved and that there are researchers at the CDC who would like to see how prevention affects HIV transmission which is difficult to assess. *SS* said that she hoped this project would encourage providers to talk more about sexual practice and prevention with their clients which is currently not happening. *LO'C* thought HIV intervention and prevention are important issues. *EW* and *Hank Wilson* expressed interest in joining the CAB.

Review and Approval of Minutes

The 2/22/99 minutes were approved, *DCB* abstained. *LCG* asked if the tentative members of the Council need to abstain from approval of minutes. *TC* said until there is an official letter of appointment from the Mayor appointees cannot vote. He asked *Bill Bourdon* if he knew what was happening with the Mayor's approval of new members. *Bill* said the recommendation is on the Mayor's desk. *LCG* said it's important for the pending appointments to be approved before the prioritization process starts.

VIII. **Committee Reports**

A. Steering Committee

Report on Unexpended funds for FY 98-99.

DJ reviewed the memo from *Herman Levias*, AIDS Office, 3/9/99, regarding voucher purchase of unexpended funds. She explained that due to the shortness of time to spend the funds the Council was limited to making voucher purchases. The difference will be added to the total unexpended funds for FY 98-99 which will be petitioned to HRSA to roll-over into the current fiscal year. She said an effort is going to be made in conjunction with the AIDS Office to prevent this situation from reoccurring. The Evaluation & Implementation Committee will discuss this subject at their next meeting, Monday, April 5, 1999. *LO* suggested the Grantee Assessment Task Force explores why the amount of unexpended funds became so large so quickly. *SK* said the timing of the Grantee Assessment should help to prevent this situation from arising next year.

Report on Unallocated funds for FY 99-00.

DJ reviewed the memo from the Steering Committee, 3/11/99, regarding unallocated funds for FY 99-00. She explained that after the shortfall from the Title I Allocation for FY 99-00, and the amount required to maintain staffing in Residential Home Care Services, the subtotal to allocate was $358,529. The Steering Committee voted to reallocate those funds as follows: Detox Beds = $177,000; Harm Reduction Outpatient Services linked to integrated service delivery programs targeting active users with the goal of increasing access to primary care and other services = $88,853; Respite Childcare = $92,676. They authorized the movement of $129,000 from Residential Home Care to Non-residential Home Care with the stipulation that "some portion of attendant cares services at residential hotels be linked to integrated service programs." *JB*, referring to the movement of $129,000, was concerned that the Steering Committee is making decisions that go beyond the scope of the Council's authorization. This

led to a discussion of how the Council now prioritizes programatically in sub-categories rather than by broad service category as they used to. This is a much more difficult process. The Evaluation & Implementation Committee, the Grantee Assessment Task Force, and the Council need to review how valuable the current process is. *MJW* pointed out that many of what are now sub-categories used to be categories. She made a motion for the Council to approve the action of the last paragraph of the memo. *TL* said that there has to be an urgent nature to vote on an item that is not on the agenda. He suggested calendaring this item to the next meeting. *JB* pointed out that a cycle of inaction is created if decisions are made by the Steering Committee that are not on their agenda, and then those decisions are brought to the Council to be ratified, which the Council cannot do because they did not ask the Steering Committee to make those decisions. After further discussion *TC* asked if there was an argument against the substance of moving $129,000 from one sub-category to another. *JB* said since these dollars were part of the unallocated funds he had no objection to their movement. *TL* recommended that anytime a Committee takes an action it should be listed on the Council's agenda as a possible vote which allows the Council to vote on that item if they chose to. *MJW* withdrew her motion. *DCB* asked that information from Committees be distributed to Council members in as timely a manner as possible.

Co-chairs Report - Prioritization/Council structure

DJ said there will be a Prioritization orientation at the April Council meeting. She circulated a list of service categories and asked Council members to sign up for the categories they were interested in for prioritization. Monthly meetings will be scheduled.

B. Membership Committee Report - *LO*

Nominations - VOTE

The Membership Committee voted to defer the application of Mike Shriver pending review.

- The Membership Committee recommended as a motion "*to forward the HSPC membership nomination of Al Terrazas to the Mayor for approval.*"
  The motion was passed by roll call vote unanimously. [Attachment A, Column 2]
- The Membership Committee recommended as a motion "*to forward the HSPC membership nomination of Council member John Conley for another two year term to the Mayor.*"
  The motion was passed by roll call vote. [Attachment A, Column 3]

There was discussion of trying to get more San Mateo County representation on the Council.

Bylaws revision - VOTE

- The Membership Committee recommended an amendment to the bylaws "*to change ARTICLE VI, Section 1, to read 'The minimum attendance required...'* (underlined text would replace 'allowed'), *and 'If there are fewer than three full Council meeting ...'* (underlined text would be added)."
  The motion was passed by roll call vote. [Attachment A, Column 4]
- The Membership Committee recommended a motion to change the bylaws, ARTICLE VI, Section 1, to read, with the approved amendments, "*The minimum attendance required is five meetings in a quarter, including at least two full Council meetings and three Committee or Task Force meetings, or other official Council activities. If there are fewer than three full Council meeting in a quarter, the minimum expectation for attendance will be reduced by the number of full Council meetings canceled.*"
  The motion was passed by roll call vote. [Attachment A, Column 5]

Attendance Review

LO announced that two Council members are out of compliance with minimum attendance requirements. The Membership Committee is required to notify members who are out of compliance before bringing a recommendation to the Council. *LO* has contacted one of the absent members and will make a recommendation at next month's Council meeting regarding the other member if necessary.

C. Needs Assessment Task Force

Gary Levinson, Director, HIV Special Projects, Support Center for Nonprofit Management, reported on the Focus Groups for the Assessment. He distributed a document covering three areas: (1) Recruitment for the Assessment by Council members; (2) guidelines for the Focus Groups; (3) Focus Group Populations. [Attachment B] He noted there are three levels of recruitment for the Assessment: General, Specialist, and Targeted. He spoke about the importance of Council participation in General Recruitment for bringing the right mix of people to the Focus Groups. He said each Council member would be sent flyers to pass out at appropriate sites. There will be 4-6 Specialist recruiters who will be paid to go to targeted

population sites where people with HIV congregate. The same 4-6 recruiters will be asked to recruit a specific number of participants for each population group. *LCG* suggested contacting Positive Resource Center for recruitment. *LO'C* asked about having separate recruiters for the target population portion. *Gary* said the Support Center would prefer fewer recruiters but was willing to discuss other possibilities. *EW* noted that Marin County will not participate in the Needs Assessment since they did one recently. He stressed that Council participation is crucial to the success of the Assessment. *LM* asked if Council members were eligible for paid recruitment. *EW* said they could be recruiters but could not participate in the Focus Groups. *SO* asked what mechanism was in place for including the needs of Marin County. *KW* said they will provide data from their Needs Assessment of last year and participate in the final analysis.

D. Evaluation & Implementation Committee
AR referred Council members to the minutes of the March meeting for clarification of the Committee's role in FY 99-00 unallocated funds. She said the Committee agreed to establish a Prioritization Task Force in April. She circulated a sign-up sheet for a REGGIE Evaluation Task Force to meet Monday, April 12, 1999, 25 Van Ness, 3-5 PM. Members expressing interest were: *TC, TL, SO.*

E. Grantee Assessment Task Force
AM reported that applications for the Assessment are due Friday, March 26,1999. They have received 2 letters of intent. The Task Force will meet Friday, April 2, 1999, 25 Van Ness, 4-6 PM, to review the proposals and make a recommendation to the Steering Committee. *TC* advised the Council that there is some political attention in Washington D.C. being focused on the Grantee Assessment. He said care needs to be taken not to mischaracterize the purpose of the Assessment, and that the intention is to improve the level of service. He said *AM* drafted a letter to Joe O'Neill, Associate Administrator, HIV/AIDS Bureau, Health Resources and Services Administration (HRSA), explaining the history of the Assessment. *DJ* said that there have been a variety of methods used by the Council over the years to assess the grantee, but since this is the first time the Council has hired an outside contractor to perform the Assessment some people are misrepresenting the significance of that. She said the letter would be included in the next Council mailing. A sign-up sheet for the Grantee Assessment Task Force was circulated. Members expressing interest were: *DCB, LCG, SJ, SK, SO.*

F. PWA Caucus
TL referred Council members to the minutes of the last Caucus meeting. He said the Caucus recommended process and outcome objectives, as well as evaluation of the Consumer Rights Advocacy Project. Evaluation includes: monitoring monthly reports of the Advocate; semi-annual project assessment; annual monitoring review with recommendation made to the Steering Committee. Community Forums will be merged with the Needs Assessment Focus Groups. *LCG* pointed out that if there is no Spanish language advocate for the Advocacy Project a brochure in Spanish will not be useful. *TL* said the Caucus is working on that issue. *DJ* said there was a discussion at the last Steering Committee meeting about defining the accountability of the Advocacy Project to the Council. A status report will be developed. It was pointed out that the letter from Toni Young to Paul Causey [Attachment A] in the minutes was incomplete. *DJ* asked that the complete letter be included in the next Council mailing. *LO'C* suggested that the priorities of the Caucus for their community forums be incorporated in the focus groups of the Needs Assessment.

G. Housing Task Force
TC said the next meeting, Friday, April 9, 1999, 25 Van Ness, Room 330-B, 12:00-2:00 PM, will focus on Prioritization. He said the February meeting focused on how the SF Redevelopment Agency (SFRA) calculates the Housing Opportunities for People With HIV (HOPWA) per unit capital subsidy. The calculation is based on a worse case scenario of people being on General Assistance. The Task Force asked that the calculation be rethought. The SFRA agreed to return next month with the requested information. He reported that the Derek Silva update suggested the heating problems there are improving. He said the net effect of redistribution of unexpended funds on housing was an increase in emergency housing vouchers. Finally, he asked Council members planning on attending the Prioritization meeting of the Task Force to review the Recommendation Summary. [Attachment B] Members who signed up for the Housing Prioritization meeting included: *TC, SJ, TL, JO, AR, EW, JAC* noted a housing problem for children of parents who die of AIDS whose survivor

benefits do not include housing vouchers. *AM* announced a meeting convened by Bill Barnes, AIDS Policy Advisor, Mayor's Office, on Friday, April 9, City Hall, 10:00 AM - 12:00 PM to discuss housing, SRO conditions, and potential solutions.

IX. AIDS Office Report - CAER Coalition/ Reauthorization

Laura Thomas, AIDS Office, distributed: (1) a letter to Joe O'Neill, HRSA, from Michelle Dixon regarding the grantee assessment; (2) a list of 1999 California State Legislation related specifically to HIV.

- She announced a proposed training to be done by the SFDPH on their contracting process in the second half of April. She will keep the Council informed.
- She said some Council members have not turned in their Form 700 which she needs by the end of this week.

Reauthorization of the Ryan White CARE Act.

The Ryan White CARE Act is up for reauthorization in September 2000. The "hold harmless" language included in the last reauthorization is of particular significance to the San Francisco EMA. There has been a loss of 1% a year over the last 5 years to the local EMA. If the "hold harmless" language was not included in the bill there would be a $9 -$15 million loss in funding. There is an opportunity now to strengthen the bill. Many national organizations are putting together position statements on reauthorization. The Communities Advocating Emergency AIDS Relief (CAER) Coalition is going to be issuing a final report on reauthorization which *Laura* will send to all Council members. She circulated a sign-up sheet for Council members interested in participating in reauthorization of the CARE Act. *SK* asked what role U.S. Congressman Tom Coburn plays in the reauthorization process. *Laura* said he sits on the House Commerce Committee which passes the CARE Act legislation. He believed CARE Act money is being misspent. *MJW* asked what happened to the HRSA draft policy on using CARE funds for housing. *Laura* said there is an ongoing discussion and a final policy will be issued in May that probably won't change much from the draft document. *TC* thinks that implementation of the housing policy is key, and that this EMA can make a strong argument for using CARE funds for housing. The most likely impact of the proposal on how housing dollars are used would be the use of HOPWA dollars for long term subsidy, and use CARE funds for transitional housing. *MJW* said the proposed policy would have an impact on housing in San Mateo County. *KW* thought the Council should respond to this issue when it comes up in the press.

X. **New Business**

- *DCB* renewed the idea of having a reception to recognize past Council members. *DJ* said she will speak to *Bill Barnes*, who has suggested the Mayor's Office participate, about this issue. *TC* suggested the Council move forward with reception plans on their own.
- *LO'C* suggested having the Council participate in a lobbying day in Sacramento.

XI. **Adjourn**

7:40 PM

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HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

3/22/99		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	*KB*	P	Y	Y	Y								
Marianna Balquiedra	*MB*	A											
Dorothy Bartolomucci	*DB*	E											
Donald Bliss	*DCB*	P	Y	Y	Y								
Chris Boehm	*CB*	A											
Jeff Byers	*JB*	P	Y	Y	Y								
Virginia Cafaro	*VC*	A											
Tom Calvanese	*TC*	P	Y	Y	Y								
Bart Casimir	*BC*	A											
Veronika Cauley	*VC*	A											
Julie Charubusapayon	*JAC*	P	Y	Y	Y								
John Conley	*JC*	P	Y										
Mark Dunlop	*MD*	A											
Gene Gowdey	*GG*	A											
Siddiq Jihad	*SJ*	P	Y	Y	Y								
Darrell Joe	*DCJ*	A											
Diane Jones	*DJ*	P	Y	Y	Y								
Tony Leone	*TL*	P	Y	Y	Y								
Allen Meyer	*AM*	P	Y	Y	Y								
Lee Ann Monfredini	*LM*	P	Y	Y	Y								
Norm Nickens	*NN*	A											
Lisa O'Connor	*LO'C*	P	Y	Y	Y								
Loras Ojeda	*LO*	P	Y	Y	Y								
Jorge Ortiz	*JO*	P	Y	Y	Y								
Stephan Oxendine	*SO*	P	Y	Y	Y								
Alissa Riker	*AR*	P	Y	Y	Y								
Nilda Rodriguez	*NR*	E											
Matthew Sharp	*MS*	A											
Susan Shea	*SS*	P	Y	Y	Y								
Kelly Wallace	*KW*	P	Y	Y	Y								
Eric Whitney	*EW*	P	Y	Y	Y								
Mary Jane Wood	*MJW*	P	Y	Y	Y								

HIV HEALTH SERVICES PLANNING COUNCIL

April 26, 1999 4:30 - 7:30 PM

Room 201 - City Hall - 1 Dr. Carlton B. Goodlett Place

Agenda

I.	Call to Order	4:30 PM
II.	Roll Call	4:35 PM
III.	Review and Approval of Agenda	4:40 PM
IV.	Review and Approval of Minutes from 3/22/99 - VOTE	4:45 PM
V.	General Announcements	4:50 PM
VI.	Public Comment	4:55 PM
VII.	Mayor's Liaison Report – Bill Barnes	5:05 PM
VIII.	Co-chairs Report	5:15 PM
IX.	Evaluation & Implementation Committee	5:30 PM
	• Unliquidated funds (98-99) – VOTE	
X.	Membership Committee	5:50 PM
	• Attendance Review – VOTE	
	• Recruitment	
	Break	6:00 PM
XI.	Steering Committee	6:15 PM
	• Grantee Assessment Report	
XII.	AIDS Office Report	6:30 PM
XIII.	Prioritization FY 2000 - 2001	6:40 PM
XIV.	Needs Assessment Report	6:50 PM
XV.	PWA Caucus	7:05 PM
	• Consumer Rights Advocate	
XVI.	New Business	7:25 PM
XVII.	Adjourn	7:30 PM

Future Meetings:

Thursday, April 29, 1999	Substance Use workgroup	815 Buena Vista West	5:30 – 7:30 PM
Wednesday, May 5, 1999	PWA Caucus	25 Van Ness Ave. Rm. 330-B	5:30 – 7:00 PM
Thursday, May 6, 1999	Membership Committee	25 Van Ness Ave. Rm. 330-B	11:00 AM – 1:00 PM
Friday, May 7, 1999	Housing workgroup	25 Van Ness Ave. Rm. 330-B	12:00 PM – 2:00 PM
Monday, May 10, 1999	Steering Committee	25 Van Ness Ave. – 5th floor	5:00 PM – 7:00 PM
Monday, May 24, 1999	Planning Council Health Care Marin/San Mateo/Support Needs Assessment	City Hall, Rm. 201	4:30 PM – 7:30 PM

SF Dept. of Public Health — AIDS Office, 25 Van Ness, 5th floor
City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

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4/26/99

May mailing
- Needs Assessment Task Force minutes 4/15/99
- Grantee Assessment Task Force minutes 4/19/99, 4/26/99
- Mental Health Prioritization minutes 4/20/99
- Planning Council minutes 4/26/99
- Substance Use Prioritization minutes 4/29/99
- PWA Caucus minutes 5/5/99
- Membership Committee minutes 5/6/99
- Health Care Prioritization minutes 5/6/99
- Housing Prioritization minutes 5/7/99
- Steering Committee minutes 5/10/99
- Job description – Consumer Rights Advocate
- Planning Council agenda 5/24/99
- Planning Council meeting calendars for May 1999, and June 1999

06-28-99P04:19 RCVD

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I. **Call to order**
4:35 PM.

II. **Roll Call**
[Attachment A, column 1] *MD assigned proxy DJ*; *LCG* was assigned proxy by *LO'C*.

III. **Review and Approval of Agenda**
Agenda approved.

IV. **Review and Approval of Minutes**
Minutes of 3/22/99 were approved. *VC* abstained. *TC* noted that the roll call and votes were missing. [Attachment B]

V. **General Announcements**
- *CB* asked the Council Co-chairs to sign a letter of support for Health Initiatives For Youth (HIFY) requesting a CARE funding grant. [Attachment C] *JC* noted that this type of item should be brought up under New Business. *TL* suggested this item be brought before the Steering Committee since it was not on the Council's agenda. *Laura Thomas* said that historically the Council Co-chairs have signed off on letters of this nature without a vote of the Council as long as it's in accordance with the Council's priorities.
- *VC* asked Council members to support commuting the death sentence of Manny Babbit.
- *NR* announced that the Council received an award of recognition from the Health Commission in honor of Public Health Week. She also distributed the April HRSA Care*ACTION* newsletter that features an article entitled Hispanics Living with HIV Disease: Barriers to Care.
- *Michael Moors* circulated a draft of Council member's address list for corrections.

VI. **Public Comment**
- *Michael Petrelis* distributed a news release regarding the alleged diversion of federal funds intended for an AIDS institute to political election campaigns in Puerto Rico. He said Congressman Tom Coburn of Oklahoma announced a federal audit by the General Accounting Office of all of the Ryan White programs.
- A representative of the Harvey Milk Democratic Club voiced support for retaining *TC* and *LO* on the Council. He was concerned that the mayor appeared to be removing people from the Council arbitrarily.
- *LO* thanked the Council members who signed the letter supporting keeping him on the Council. He said he tried to bring a Latino perspective to the Council. He was concerned that the process is being politicized and that the community based structure of the Council is at odds with the wishes of the Mayor's Office. He pointed out that the Council is a federally mandated organization that needs to be kept autonomous.
- *Dave Jenson*, Treasurer, AIDS Emergency Fund, supports retaining current membership of the Council.
- *Hank Wilson* said the Council needs reliable members which both *TC* and *LO* are. He said those members of the Council who do not attend meetings should be removed from the Council. He

asked to keep PWA representation on the Council. He said it was important to keep the Council independent. Committed members are important to the success of the Council.

- *Frederick Hobson* was disturbed that politics has entered the process of the Council. He said he supports the mayor in many things but has to part company with him on this issue. He said he has known *TC* for 10 years and that the quality of the work Tom has for the community is impeccable.
- *Michael Larra*, Act Up Golden Gate, distributed flyers and posters for AIDS Candlelight Vigil, Sunday, May 16, 1999, Castro & Market streets at 8:00 PM. This year hero and heroine awards will be given at the ceremony. He also voiced support for people with AIDS on the Council and urged keeping politicization of the Council to a minimum.
- *LCG* said she wants to hear the reasons why *LO* was removed from the Council since he represents the Latino and HIV+ communities both of which are underrepresented on the Council. She said *LO* fills an important role representing the native Latino population.

VII. **Mayor's Liaison Report**

Bill Barnes, AIDS Policy Advisor, Mayor's Office, distributed two documents from Los Angeles County: a fair share analysis that suggests the San Francisco EMA gets 18 million more than it should, and a position paper on Ryan White reauthorization which suggests eliminating the "hold harmless" clause. He introduced *Steve Kawa*, Director of Legislative Affairs, Mayor's Office who spoke about his meeting with the Council Co-chairs to discuss questions of membership, terms and bylaws of the Council. He said the mayor has to make difficult decisions about appointments. He suggested staggered terms of appointment. He asked that the vacant seats on the Council be filled quickly. He said he would make sure the Council gets a list of people who have expressed interest to the Mayor in serving the community. He said the membership issue is solvable. *DJ* asked about the reappointment of *TC* and *LO*. *Mr. Kawa* said he had sent a letter to *TC* on behalf of the mayor asking him to remain on the Council until the mayor can find a replacement. He declined to say why *LO* was not reappointed. He asked for a list of three names for each vacant slot on the Council. *LO* said the Council had tried repeatedly to get the administration to appoint new members over the course of the last several months. *VC* voiced her concern that *LO* has been a very effective member on the Council and did not think the Council could work effectively with the Mayor's Office until this issue is addressed. *SJ* asked if the mayor acknowledges the Council's appointment process and terms or if he expects members to serve at his pleasure. *Mr. Kawa* said he was offering the services of his office to come to a resolution about appointment dates and terms. SJ said that did not answer his question. DJ said the Council has a process in place established over the last two years that has clearly defined membership appointment dates and terms. The Mayor's Office has a different set of dates. She was concerned that there now seems to be a quota of names that must be submitted to the mayor for him to select from that did not exist before. She pointed out that since the mayor has removed the Chair of the Membership Committee it is unrealistic to expect the Council to come up with 24 names of potential new members in the near future. *Mr. Kawa* said he hoped the Council could get beyond this to address the important issues coming up this year. *TC* said this is an example of what is the worst of what goes on in the political arena. He said he joined the Council to help give people the authority to make decisions about their lives. He has tried to create a safe place for people to become part of the process of making change. He said the politicians are wrong to think they can stop community-based organizations. He read the letter he received from Steve Kawa, [Attachment D] and wondered how it clarified the expiration date of his term. He said it felt like he was removed from the Council because he said or did something that the mayor, or someone in his administration, did not approve of and is being reinstated because of public pressure. He said he feels like a political football and that it seems the mayor is only interested in appointing people who won't take a stand on issues. He said the Mayor's Office views the Council like a city commission with no authority and serving at the pleasure of the Mayor which makes it impossible for the Council to do the important work that it is mandated to do by HRSA. He said the starting point for working out the differences between the Council and the Mayor's Office needs to the legislation that created the Council and the bylaws of the Council, not an arbitrary decision from the Mayor's Office. *LAM* asked *Steve Kawa* to provide the Council with a list of people who want to volunteer, and suggested the Membership Committee put together a list of applicants as soon as possible. *DJ* suggested this discussion be deferred to the Membership Committee item on the agenda. She pointed out that it is unrealistic to expect the Council to come up with 24 names by May 15th. *VC* said it doesn't make sense not to reappoint people who have served the Council faithfully. *SS* was disturbed that the rules have been changed without consulting the Council and wondered if the mayor might consider putting his decision on hold for 6 months until the Council and his office can work out the details. She said it's important to determine whether the

Council has some say in who gets appointed to it. *TC* said that the HRSA guidelines as well as the Council's bylaws make it clear that it is not appropriate to have the Mayor's Office submit names for membership on the Council. *SO* said he is actively not recruiting new members to the Council because he feels it has not been the best use of his time dealing with issues like this one. The hours spent arguing with the Mayor's Office would be better spent elsewhere. *LCG* said the mayor's action had a chilling effect on Council members who will now think twice before speaking out. *Bill Barnes* said there's important work to be done and urged the Council to move ahead. *DJ* said she felt the Council couldn't move on until this issue is resolved, and that past meetings with the Mayor's Office have led to the current situation. This situation is jeopardizing the grant and ultimately services to people with HIV/AIDS. She said a public debate was needed to discuss the relationship of the Council to the DPH and the Mayor's Office. *MS* announced that Act Up Golden Gate is co-sponsor of a public debate on this issue, set for May 17th, 6:00 – 8:00 PM, the location is yet to be determined. *SS* said it would be a mistake to simply move forward and appoint a new Membership Committee Chair. *NR* stated that she had joined the Council to fight to save lives of people with HIV/AIDS and wants to continue to work for those beliefs. She noted that the Council has changed dramatically since *TC* has been Co-chair and thought it was a shame to see his talents removed from the Council for political reasons.

VIII. **Co-chairs Report**
None.

IX. **Evaluation & Implementation Committee (EIC) Report**
Unobligated and unliquidated funds. *DJ* distributed a memo from the Steering Committee regarding unliquidated funds. [Attachment D] It defined unobligated funds as those that do not become incorporated into contracts, and unliquidated funds as those that become available when contractors are not able to use the full amount in their contracts. She asked that Council members learn and use these terms. The EIC had a productive meeting with the AO out of which came two proposals that were forwarded to and approved by the Steering Committee:

(1) The AO will attempt to maintain funds within their original category. The Planning Council will determine use of unobligated or unliquidated funds when needs have changed. The AO will attempt to notify the Council of the availability of these funds on a regular basis to maximize the options for their use.

(2) The use of unliquidated funds from FY 98-99. The following categories came from the FY 99-00 prioritization (except #1) and were noted therein as uses of one-time funds.
   1. Augment the Congressional Black Caucus (CBC) initiative proposal to expand the target population to include Latino men, women and transgenders.
   2. Direct Emergency Financial Assistance.
   3. Vouchers for transportation, housing, and if possible, childcare and pharmacy co-payments.
   4. Contractor and provider trainings.
   5. Outreach and media campaigns to educate clients about existing services.
   6. Equipment, computers, and furnishings.
   7. Non-ADAP drugs.

The AO will use this list to formulate a proposal for use of unliquidated funds that will be submitted to the Steering Committee and forwarded to the Council in June. A request to HRSA based on the Council's decision will be made to rollover these funds to be spent in FY 99-00. The list is ranked in order of priority. *KW* had two questions: (1) how augmenting the CBC initiative got to the top of the list when there has been no previous discussion of it during prioritization, and (2) what was included in the category of contractor and provider trainings. *Laura Thomas* said a number of trainings were listed in the prioritization last year and any proposal of the AO will be based on those recommendations. *BC* asked if there would be any of these funds would support the mental health category. *DJ* thought it was included in items #4 and #5. *AM* asked if one-time funding of the CBC initiative would work. *Laura Thomas* said would assist in getting the program started and the Council will have to decide next year if it's worth on-going funding. *SO* asked what the dollar amount in unliquidated funds is. *DJ* said that figure will not be known until the end of May. *TC* recommended adding language to proposal #2 making it clear that the list is based on last year's prioritization.

- *Proposal #2 was submitted as a motion for the Council's vote.*
  The motion passed. [Attachment A, column 2]

REGGIE Evaluation Task Force. *GG* reported that the Task Force had their first meeting April 12th, and have scheduled their next meeting for Tuesday, May 11th, from 3:00 – 5:00 PM, 25 Van

Ness Ave., Rm. 330-B. He encouraged Council members, AO representatives, and providers who use REGGIE to attend that meeting. The Task Force reviewed the REGGIE survey produced by the S.F. HIV Contractors Association and found about half of the respondents were in favor of REGGIE and the other half were having difficulties implementing REGGIE at their sites. The system seems to work better for smaller agencies that are not linked to a large system. The Task Force is reviewing the contract language that makes REGGIE mandatory.

X. **Membership Committee Report**

TC asked that the Membership Committee Report be referred to the Membership Committee meeting of May 6th. *JC* asked what would happen to the vote for attendance review that was on the agenda. *DJ* said that due to the current circumstance of having no Chair for the Membership Committee there needs to be further discussion of attendance at that Committee level before being brought to the Council for a vote. *KW* asked if the Council has records of membership appointment dates. They do. *Bill Barnes* said he would make copies of the appointment dates the Mayor's Office has for the Council.

XI. **Steering Committee Report**

Grantee Assessment Task Force. *AM* announced the recommendation of the Task Force to hire The Bernal Group for the grantee assessment and the Steering Committee's vote to accept the recommendation. He said the contract should be in place by the end of the current week. *Barbara Rosa*, President, The Bernal Group, said she will work for the Council through the Task Force and hopes to achieve a better delivery system for people with HIV/AIDS. *AM* pointed out they are slightly behind in their timeline, but hope to have a draft of the assessment to the Council by the end of July with a final report due by August 30th.

XII. **AIDS Office Report**

Laura Thomas

- distributed the CAEAR Coalition Position Paper: Ryan White CARE Act Reauthorization, which she noted, was the final version, not a draft as stated.
- circulated a sign-up sheet for the document Participation of People Living with HIV in State HIV Care Planning and Programs.
- announced HRSA's HIV/AIDS Bureau's Technical Assistance Conference Call Series. The first of these will address Outcomes Evaluation on Wednesday, April 28th, at 11:00 AM.
- announced the AO contract training on April 28th, from 2:00 – 5:00 PM in the AO 5th floor conference room.
- said the AIDS lobby day in Sacramento was a success.

Michelle Dixon announced a memorial service for Reggie Williams, Thursday, April 29th, West Bay Conference Center, Fillmore and Eddy streets, 6:00 – 8:00 PM.

XIII. **Prioritization FY 2000-01**

DJ distributed:

- the Priority Setting section from HRSA's Ryan White CARE Act Title I manual which spells out legislative requirements, DHS expectations, steps in priority setting, and resource allocation.
- FY 2000-01 Prioritization Plan timeline for April through August.
- FY 2000-01 CARE Prioritization overview/consensus.
- 1999-2000 CARE Prioritization Defining Severe Need.

She said the only change to the last two documents from last year was the addition of #8 to the overview/consensus to produce a two-year plan, building on the past two years' prioritization plans and the evaluation of their implementation. She asked the workgroups to keep the process simple and to spell out differences when they could not reach consensus.

XIV. **Needs Assessment Report**

EW reported that the Needs Assessment Task Force has asked the contractors to present data to them on June 14th so that any corrections can be made before the final report to the Council on June 28th. He encouraged Council members who were interested to attend that meeting. The assessment is moving along well. He said there are a small number of focus groups that are still not full including Filipino, youth, monolingual Spanish, and Native American. The service provider survey for social services has gone out. The health care provider survey is ready to be administered. The return-to-work portion is proceeding.

XV. **PWA Caucus Report**

TL reported that

- a letter from Toni Young to Michelle Long-Dixon, Director, AO, addressing the matter of PWA's who have been disqualified from receiving service because of time issues was modified and approved by the Caucus.
- there is a problem with availability of bus tokens for PWA's within the city which the Caucus is looking into.
- *NR* encouraged members to support the Bridge Housing Corporation housing facility at 1 Church Street, which would include 12 HOPWA units.
- the March report of the Consumer Rights Advocate included development of a Spanish language campaign; Michael Began has been hired to assist with peer advocacy.
- the HIV Consumer Rights Advocacy Project contract expired February 28th. After modification of the contract prior to renewal, Toni Young, the contractor declined to participate in further negotiations. She has agreed to stay through June 30th, and the Caucus has developed a transition plan. Toni has been asked to write a job description for the newly formed Jobs Committee formed by the Caucus. The Committee will meet Friday, May 7th, in the AO Training Room A, 3:30 – 5:30 PM. A draft of the job packet will be presented to the Steering Committee Monday, May 10th. The packet will be mailed to Council members by May 17th. If the Council approves the job description at its May 24th meeting advertisement will begin May 25th. Resumes are due June 11th, and the new hire begins June 23rd. *TL* said the new contract would be handled differently with fiscal oversight being done by the Support Center for Nonprofit Management. *Bill Barnes* suggested that some legal assistance for the Project might be available through the AIDS Legal Referral Panel. *TC* suggested having discussion of that subject at the next PWA Caucus meeting.

XVI. **New Business**

VC announced that she will not be appearing on the cover of POZ magazine next month as previously thought, and that she will be gone during May and June. She has given her proxy to SJ.

XVII. **Adjourn**

7:40 PM

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HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

4/26/99		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	*KB*	P											
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Donald Bliss	*DCB*	P	Y										
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Julie Charubusapayon	*JAC*	P											
John Conley	*JC*	P	Y										
Luis De La Torre	*LDT*	E											
Mark Dunlop	*MD*	A											
Gene Gowdey	*GG*	P	Y										
Laura C. Guzman	*LCG*	P	Y										
Siddiq Jihad	*SJ*	P	Y										
Darrell Joe	*DCJ*	P											
Diane Jones	*DJ*	P	Y										
Samuel Kaplan	*SK*	P	Y										
Tony Leone	*TL*	P	Y										
Allen Meyer	*AM*	P	Y										
Lee Ann Monfredini	*LM*	P											
Norm Nickens	*NN*	P											
Lisa O'Connor	*LO'C*	E											
Loras Ojeda	*LO*	P											
Jorge Ortiz	*JO*	P	Y										
Stephan Oxendine	*SO*	P	N										
Alissa Riker	*AR*	P	Y										
Nilda Rodriguez	*NR*	P	Y										
Matthew Sharp	*MS*	P	Y										
Susan Shea	*SS*	P	Y										
Kelly Wallace	*KW*	P	Y										
Eric Whitney	*EW*	P	Y										
Mary Jane Wood	*MJW*	E											

HIV Health Services Planning Council
Community Forum

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JUN 23 1999

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Report

To: Members, HIV Health Services Planning Council
Meeting Date: May 17, 1999
Meeting Place: Metropolitan Community Church, 150 Eureka Street
Meeting Time: 6:00 to 8:00 PM

Members Present: Don Bliss, Chris Boehm, Tom Calvanese, John Conley, Laura C. Guzmán, Diane Jones, Norm Nickens, Lisa O'Connor, Loras Ojeda, Nilda Rodriquez, Matt Sharp, Eric Whitney.

Community forum on HIV Health Services Planning Council membership
MS introduced the community forum, co-sponsored by Act Up Golden Gate and the Harvey Milk Democratic Club, to discuss the removal of *TC* and *LO* from the Planning Council by the mayor. He voiced concern that the situation is not being resolved and said that politics needs to be taken out of the process.

DJ gave an overview of the history of the Council as an activist organization based on the premise that clients make the best advocates. She explained that there are three bodies that comprise the Emergency Metropolitan Area: (1) the mayor, the Chief Elected Official who assigns the grantee and appoints HIV Health Services Planning Council members; (2) the Department of Public Health's AIDS Office, the grantee that distributes the Ryan White CARE Act funds; (3) the HIV Health Services Planning Council, the body that prioritizes spending the Ryan White CARE Act funds. She said the Health Resources and Services Administration (HRSA) oversees the Ryan White CARE Act and mandated that the makeup of the Planning Council reflect the local community. She said the bylaws of the Council require that 51% of its members be HIV positive, and that 25% of its members must be recipients of CARE funded services. *NN* said that eleven or twelve seats on the Council are mandated by HRSA to represent health care providers.

TC distributed excerpts from the Planning Council bylaws. [Attachment A] He explained that the mayor appoints members to the Council from a pool of names provided by the Council. Mayor Brown is the first mayor to exercise the power of reappointment, which the Council felt was confusing since the dates the mayor has used for assigning reappointment don't match the records of appointment used by the Council. The Council passed an attachment to their bylaws assigning members terms of two years. When a member's term is over they can apply to the Council for appointment to further terms, but are not automatically eligible for reappointment by the mayor. He said the current conflict with the mayor is about whether the membership of the Council is a community based or political process. If Council members serve at the pleasure of the mayor that is a different reading of the HRSA guidelines than the Council has interpreted them to be. He said the mayor does not believe the Council has the authority to set terms for its' members.

Discussion
- *Michael Petrelis* said the issue of membership terms for the Council is complicated, and wondered how it affects CARE Act clients.
- *Philip Babcock* asked how the reduced number of Council members is affecting prioritization.
- *Mary Fraiser* suggested the length of term for Council members should be longer than two years.
- *NN* said the reauthorization of the CARE Act required modification of the Council's bylaws that coincided with the appointment of Mayor Brown who has a different style of management than previous mayors did. He said the process of the Council would get more difficult as dollars get more scarce.
- *TC* felt there were dangerous forces coming together with decreasing funds and increasing influence from the mayor, and that under those circumstances it's even more important for the Council to represent clients.

- *NR* recounted her experience of being told her reappointment would be held up by the Mayor's Office because she voted against the mayor on his funding request for mental health.

- *Jeff Sheehy* reported that Steve Kawa, Director of Finance, Mayor's Office, said the Council is not doing its job.
- *Michael Shriver* said that local dollars for substance use is shrinking and that pressure needs to be put on the mayor to increase his commitment to funding substance use treatment. He also said the National Governors Association wants block grant funding for the CARE Act, and that the states will not support the community planning process. He suggested the Council get legal council on their bylaws changes.
- *Michael Petrelis* said the Health Commission does not support the community process. He hoped the forthcoming audit of the AIDS Office would bring more accountability to the process.
- *LCG* noted that the mayor held up her nomination for over six months, and that she was only appointed after the Council put additional pressure on the mayor.
- *Doug Comstock* suggested the Council demand to know why the mayor is trying to reform them.
- *Gregory Rowe* thought the CARE Act was based on democratic principles and that this shift of power to the chief executive set a dangerous precedent.
- *Loras Ojeda* said, as an HIV positive Latino, he brought important representation to the Council. He said there needs to be a clear message sent to the mayor concerning the future of the Council and whose vision that future represents.

Next steps

- *DJ* said the Council has been locked in this struggle with the Mayor's Office for months, and that it is time to move forward as a community. She said no one from the Mayor's Office has ever had discussion with the Council about the state of HIV services. She felt it was important to communicate to the public the danger of losing the power of the Council.
- *MS* asked people to come to Council meetings and speak out about this issue.
- *Michael Shriver* suggested people plan community action through ACT UP Golden Gate.
- *Jeff Sheehy* said there needs to be an action group to move this issue forward. He suggested representatives of the Council meet directly with Louise Renne to get the perspective of the City Attorney's Office.
- *TC* said the support needs to start with the Council.
- *Michael Petrelis* said the Council does not do a good job of expressing what it is they do. He suggested they speak more about what they do, encourage clients to participate and to address their issues to the Health Commission.
- *LCG* suggested the need for forums to link communities together.

HIV HEALTH SERVICES PLANNING COUNCIL

May 24, 1999 4:30 - 7:30 PM

Room 201 - City Hall - 1 Dr. Carlton B. Goodlett Place

Agenda

I.	Call to Order	4:30 PM
II.	Roll Call	4:35 PM
III.	Review and Approval of Agenda	4:40 PM
IV.	Review and Approval of Minutes from 4/26/99 - VOTE	4:45 PM
V.	General Announcements	4:50 PM
VI.	Public Comment	4:55 PM
VII.	Mayor's Liaison Report – Bill Barnes	5:10 PM
VIII.	Co-chairs Report	5:15 PM
IX.	Membership Committee	5:25 PM
	• Nominations – VOTE	
	• Bylaws Attachment A - VOTE	
	• Attendance Review – VOTE	
X.	Needs Assessment	5:55 PM
	Break	6:00 PM
XI.	PWA Caucus	
	• HIV Consumer Rights Advocate Project - VOTE	6:15 PM
XII.	AIDS Office Report	6:30 PM
XIII.	Prioritization FY 2000 – 2001	6:45 PM
	• CARE/REGGIE URS (Anne Hirozawa)	
	• HIV/AIDS Prevalence (Laura Thomas)	
	• DPH Plan (Jimmy Loyce)	
XIV.	New Business	7:25 PM
XV.	Adjourn	7:30 PM

SF Dept. of Public Health — AIDS Office, 25 Van Ness, 5th floor
City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council Members, are available for inspection and copying. For further information, call the Council's staff, 415-554-9136. The closest accessible BART Station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #71 Haight/Noriega, #9 San Bruno, F Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 923-6142. *Minutes of Meetings are tentative until formally approved by the Council.*

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HIV HEALTH SERVICES PLANNING COUNCIL

Meeting calendar for May 1999:

DATE	GROUP	PLACE	TIME
Wednesday, May 5	PWA Caucus	25 Van Ness Ave. Rm. 330-B	5:30 – 7:00 PM
Thursday, May 6	Grantee Assessment Task Force	25 Van Ness Ave. 8th floor	10:00–11:00 AM
Thursday, May 6	Membership Committee	25 Van Ness Ave. Rm. 330-B	11 AM – 1 PM
Thursday, May 6	Health Care Prioritization	25 Van Ness Ave. Rm. 330-A	4:00 – 6:00 PM
Friday, May 7	Housing Prioritization	25 Van Ness Ave. Rm. 330-A	12:00–2:00 PM
Monday, May 10	Steering Committee	25 Van Ness Ave. 5th floor	5:00 – 7:00 PM
Tuesday, May 11	REGGIE Evaluation	25 Van Ness Ave. Rm.330-B	3:00 - 5:00 PM
Monday, May 17	Mental Health Prioritization	25 Van Ness Ave. Rm.330-A	4:00 - 6:00 PM
Wednesday, May 19	Membership Committee	25 Van Ness Ave. Rm.330-A	2:30 – 4:30 PM
Wednesday, May 19	Needs Assessment Task Force	25 Van Ness Ave. Rm.330-B	5:30 – 7:30 PM
Thursday, May 20	Counties/Support Prioritization	25 Van Ness Ave. Rm.330-B	4:00 - 6:00 PM
Thursday, May 20	Substance Use Prioritization	815 Buena Vista West	5:30 – 7:00 PM
Friday, May 21	Grantee Assessment Task Force	25 Van Ness Ave. 5th floor	4:00 – 6:00 PM
Monday, May 24	Planning Council	City Hall, Rm. 201	4:30 – 7:30 PM
Wednesday, May 26	Housing Prioritization	25 Van Ness Ave. Rm. 330-A	4:00 – 6:00 PM
Thursday, May 27	Needs Assessment Task Force	25 Van Ness Ave.Rm. 330-B	5:30 - 7:30 PM

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HIV HEALTH SERVICES PLANNING COUNCIL

Meeting calendar for June 1999:

DATE	GROUP	PLACE	TIME
Wednesday, June 2	PWA Caucus	25 Van Ness Ave. Rm. 330-B	5:30 – 7:00 PM
Thursday, June 3	Health Care Prioritization	25 Van Ness Ave. Rm.330-A	5:00 – 7:00 PM
Monday, June 7	Mental Health Prioritization	25 Van Ness Ave. Rm.330-A	4:00 - 6:00 PM
Thursday, June 10	Integrated Services presentation	25 Van Ness Ave. Rm.330-A	5:30 – 7:30 PM
Tuesday, June 15	Counties/Support Services Prioritization	25 Van Ness Ave. Rm.330-B	4:00 – 6:00 PM
Wednesday, June 16	Housing Prioritization	25 Van Ness Ave. Rm.330-A	4:00 - 6:00 PM
Thursday, June 17	Substance Use Prioritization	815 Buena Vista West	5:30 – 7:00 PM
Monday, June 21	Research Presentation	25 Van Ness Ave. Rm. 330-A	5:00 – 7:00 PM
Thursday, June 24	Health Care Prioritization	25 Van Ness Ave. Rm. 330-A	5:00 – 7:00 PM

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Date: 5/17/99

To: HIV Health Services Planning Council

From: Michael Moors

RE: Prioritization Workgroups

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Dear Council members:

If you have not signed up for a prioritization workgroup (see table) now is your opportunity to do so. Please remember that the revised bylaws require attendance of at least one monthly Council related meeting in addition to the full Council meeting.

Prioritization Groups		Housing	Health Care	Mental Health	Substance Use	M/SM Support
Kirsten Balano	*KB*		X			
Dorothy Bartolomucci	*DB*					
Donald Bliss	*DCB*			X	X	
Chris Boehm	*CB*					
Jeff Byers	*JB*					
Virginia Cafaro	*VC*					
Tom Calvanese	*TC*	X				
Bart Casimir	*BC*					
Veronika Cauley	*VC*					
Julie Charubusapayon	*JAC*		X			X
John Conley	*JC*		X			X
Luis De La Torre	*LD*	X				X
Mark Dunlop	*MD*					
Gene Gowdey	*GG*					
Laura C. Guzmán	*LCG*			X	X	
Siddiq Jihad	*SJ*	X			X	X
Darrell Joe	*DCJ*					
Diane Jones	*DJ*		X	X	X	
Tony Leone	*TL*	X				
Allen Meyer	*AM*		X			
Leann Monfredini	*LM*					
Norm Nickens	*NN*					
Lisa O'Connor	*LO'C*				X	
Loras Ojeda	*LO*					
Jorge Ortiz	*JO*	X	X			
Stephan Oxendine	*SO*		X			X
Alissa Riker	*AR*	X				
Nilda Rodriguez	*NR*		X		X	X
Matthew Sharp	*MS*					
Susan Shea	*SS*		X			
Kelly Wallace	*KW*					X
Eric Whitney	*EW*	X				
Mary Jane Wood	*MJW*			X		X

HIV Health Services Planning Council
PWA Caucus
SF Dept. of Public Health, AIDS Office
25 Van Ness Avenue, 5th floor
San Francisco, CA 94102-6033

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Job Description
HIV Consumer Rights Advocate

Name of position:
HIV Consumer Rights Advocate.

Overview of project:
The HIV Consumer Rights Advocacy Project is a project of the HIV Health Services Planning Council (i.e. CARE Council) and the PWA Caucus of the Council. The propose of this project is to provide advocacy services on behalf of clients of CARE funded agencies following unsatisfactory resolution of client issues through internal agency procedures. Referrals to existing agencies are made as appropriate.

Description of position:
This consultant position involves the following.

1. Evaluates complaints of clients,
2. represents clients in meetings with representatives of CARE funded agencies and other related agencies,
3. advocates on behalf of clients,
4. works toward satisfactory resolution of complaints,
5. creates and maintains a confidential database of client issues/complaints,
6. tracks the database by type of complaint/agency and other relevant criteria,
7. meets with and reports monthly to the PWA Caucus,
8. meets monthly with the designated Council Co-chair and the designated PWA Caucus Co-chair, and
9. reports any policy issues which may arise or become apparent during the course of handling client issues to the PWA Caucus.

Position reports to:
This position reports directly to a designated Co-chair of the PWA Caucus and a designated Co-chair of the HIV Health Services Planning Council.
The PWA Caucus is responsible for the oversight and strategic planning of this position. The membership of the PWA Caucus is composed of both Council members and non-members.

The Steering Committee of the HIV Health Services Planning Council is responsible for review and approval of the Memorandum of Understanding (MOU) for the position following the review and recommendation of the PWA Caucus.

Position supervises:

The position may supervise outreach workers, peer advocates, clerical workers, and others who may be hired in consultation with the designated co-chairs to accomplish the tasks of the project.

Major responsibilities:

1. assists clients with processing of their issues/complaints once the client has completed the agency's internal grievance process,
2. makes referrals to other agencies as appropriate,
3. works as a team member with the PWA Caucus on policy issues,
4. maintains a confidential database and tracks client issues/complaints,
5. assists the PWA Caucus in the development of project goals,
6. attends a minimum of two monthly meetings - one with the PWA Caucus and the other with the designated Co-chairs of the PWA Caucus and Council,
7. drafts written reports,
8. provides community presentations,
9. develops a media and public information plan for the project, including Spanish language translations,
10. conducts client satisfaction surveys, and
11. locates and manages office space for project.

Qualifications:

While there are no exact criteria for this position, your experience should reflect much of the following.

1. Knowledge of the needs of people living with HIV/AIDS in the City & County of San Francisco, AIDS service providers, and the SF Department of Public Health;
2. knowledge of concepts, strategies and interventions related to HIV/AIDS;
3. knowledge of policies and procedures related to CARE funded programs;
4. ability to manage vendors;
5. ability to provide effective oral and written communication;
6. ability to work as a team member;
7. ability to engage effectively as an advocate;
8. ability to satisfactorily negotiate resolution of complaints;
9. knowledge of mediation process; and
10. ability to work strategically to implement a new and evolving project.

Education:

Bachelor's Degree preferred, however experience can substitute in place of education.

Fees and Expenses:

Consultant fees range from $22 to $26 per hour (for up to 30 hours per week), without benefits. Reimbursement for operating expenses.

Deadline for Résumés:

Résumés must be received by 5:00 PM, Thursday, June 10, 1999.
People living with HIV/AIDS, people of color, and women are encouraged to apply.

Send résumé and cover letter to:

HIV Consumer Rights Advocate
Attn: Nilda Rodriguez, Co-chair
c/o Gary Levinson, Director, HIV Special Projects
Support Center for Nonprofit Management
706 Mission Street, 5th floor
San Francisco, CA 94103-3113

Phone: 415-560-7472

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2
1/24/99

Minutes, May 24, 1999 HIV Health Services Planning Council

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I. **Call to order**
5:10 PM.

II. **Roll Call**
[Attachment A, column 1] VC assigned proxy to *SJ*; CB assigned proxy to *TC*.

III. **Review and Approval of Agenda**
Agenda approved.

IV. **Review and Approval of Minutes**
Minutes of 4/26/99 were approved. *DCB* abstained. *SK* noted that Attachment E was missing. Attachments D and E should not have been listed as attachments since these documents were distributed at the Council meeting.

V. **General Announcements**
- *NR* announced that *DJ* is out of town for a week. She also noted that *TL* is in the hospital.
- *MS* announced the Treatment Education Certification Program (TECP) is presenting a three hour provider workgroup session on return to work, Wednesday, May 26, Asian Pacific Islander Wellness Center. In addition, the TECP is recruiting providers of AIDS service organizations for subsequent trainings in June and July.

VI. **Public Comment**
- *Jim Illig*, President, HIV Contractors Association, announced a conference Tuesday, May 25, 1999, at St. Mary's Cathedral, 8:00 AM – 2:00 PM on critical public policy and its affect on San Francisco's nonprofit organizations. There will be workshops on the living wage, Sunshine Act, lobbying and advocacy, and unionization. In addition, he stated that he is the Chair of the Board of Supervisors Living Wage Task Force. He voiced concern about the cost of the proposed increase in minimum wage to nonprofit organizations. He said the task force has commissioned an economic impact report that will take about three months. On Tuesday, June 1, 1999, at 2:00 PM, the Board of Supervisors will vote on whether to delay its vote until the economic analysis is finished. He said CARE contractors will be affected by a vote to support the living wage increase resulting in a cut in services, and encouraged Council members to attend the meeting.
- *Peggy Taylor Campbell* announced that *TC* was given a hero award at the Candlelight Vigil last week. ACT UP Golden Gate and the Sisters of Perpetual Indulgence sponsored the event.
- *Gene London*, nominee to the Council, introduced himself. He is the Director of HIV Program and Community Acupuncture Programs at the American College of Traditional Chinese Medicine. He would bring his experience with Chinese medicine and natural therapies to the Council and would advocate for those forms of therapy.
- *Hank Wilson*, ACT UP Golden Gate, supports community planning process. He presented *TC* the Bill Krause leadership award at the Harvey Milk gay, lesbian, bisexual, transgender dinner last week.
- *Michael Siever*, co-chair, Treatment on Demand Planning Council, supports the CARE Council in their efforts to keep politics out of the membership election process. He voiced concern that as CARE funds are reduced there will be more pressure for the Council to conform to requests from the Mayor's Office, and encouraged the Council to remain independent.
- *Doug Comstock* urged the Council to remain independent from the Mayor's Office.
- *Camile Moran*, patient rights advocate, spoke in favor children's rights, the need for psychiatric drugs, and mental health treatment.
- *Andrew Wicker*, Project Manager, Bridge Project, voiced concern regarding the loss of a full time home health worker from the Bridge Project in the Tenderloin. The loss occurred when the contract for this position was transferred from VMH to Health at Home. He said the services offered by this position have been invaluable to their clients and fits the integrated service model recommended by the Council. He asked the Council to support the continuation of this position. *SJ* asked what specifically he was asking the Council to do. *Andrew* said he would be meeting with the AIDS Office to argue their case. *LCG* said there was a discussion with *Russ Zellers*, AIDS Office, regarding the importance of this position *NR*

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referred further discussion of the subject to the Mental Health and Health Care prioritization workgroups. *TC* said this is an implementation issue that arose due to contract language. He said the Council has already stated their support of flexibility in home health care, and he is involved in discussions with the AIDS Office on this subject.

- *Richard Hammer* urged that the work of the Council not become politicized.
- *Andrew Farley* asked the CARE Council to help him keep his home attendant. He said AIDS patients sometimes need help to remain independent.
- *Crystal Meadow*, President, Harvey Milk Democratic Club (HMDC), said that *TC* was given Bill Kraus award because of the way he has changed the Council to more accurately reflect the community it serves. He said the Council is on the right track and should not have the specter of getting kicked off over their heads. He said it's important that the community support the Council. He also spoke as a union organizer regarding the upcoming conference to discuss living wages, mentioned by Jim Illig, and said that it should include discussion of executive wages at agencies which seem out of line with the funding for their services.
- *Alliena Baker*, nominee to the Council, introduced herself. She is a Peer Advocate for the Filipino Task Force on AIDS, and would bring her experience as an HIV positive Filipina to the Council.
- *NR* announced a joint planning council meeting on integrated services, June 4, 1999, 101 Grove St., 3rd floor, 3:00 PM, *MS* said peer and treatment advocates were invited to this meeting to give their perspective on how well integrated services are working.

VII. **Mayor's Liaison Report**

Bill Bourdon, Deputy AIDS Policy Advisor to the Mayor, supported the need to enhance the community development process. He said there was a meeting last week between the Council co-chairs and representatives of the Mayor's Office that was productive. He said the Ryan White CARE Act is up for reauthorization in September and that the city must develop a position statement. He encouraged the Council to co-sponsor an event to educate the community about the importance of the CARE Act. Bill Barnes is currently in Washington D.C. working on reauthorization.

VIII. **Co-chairs Report**

TC thanked the Council for being supportive during the current difficult time and urged members to focus on the work that needs to be done during prioritization. *DJ* and he met with Steve Kawa, Bill Barnes and Brad Benson to discuss the mandate of the Council from HRSA and what the Council's bylaws state. He distributed Attachment A of the Council's bylaws and explained the intent of two year terms which was to insure the voices of people living with HIV/AIDS continue to be heard as members of the Council. He said Steve Kawa understood the intent of the Council. He said there should be a written report from the Mayor's Office on their discussion. He said the status of *LO* is still unknown. *LO* thanked the Council for their support and said he needs clarification from the mayor as well as a statement of the council's support before returning as a member. *MS* suggested members call the mayor personally to encourage resolution of this issue. *KW* noted that five members' terms expire next month and wondered what needs to be done regarding those members. *TC* said their names would be included in a letter of membership recommendations to the mayor.

TC distributed a Request for approval of the FY 1999-2000 Ryan White Comprehensive AIDS Emergency Act with CARE funded agencies.

IX. **Membership Committee Report**

BYLAWS ATTACHMENT - VOTE

LCG referred to Attachment A saying the expiration dates for members terms are based on their original letters of appointment from the mayor. Taline Sanassarian of the Mayor's Office will keep track of those dates. *JC* pointed out that items #9 and #10 require the mayor to give specific reasons for not appointing people to the council and may invite litigation. He said that, although he approves two-year terms, he couldn't vote to extend his own term. *TC* said the mayor thought Attachment A was "reasonable", and that the wording came directly from HRSA guidelines regarding the mayor's need to justify not appointing members. *LDLT* voiced concern that the length of term be two years in order for new members to have time to become useful participants on the council. He also requested an orientation meeting for new members.

- **The council voted to approve Bylaws Attachment A.** [Attachment A, column 2]

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NOMINATIONS – VOTE

LCG distributed the recommendations of the membership committee and reviewed the nominees. The committee strongly recommended Al Terrazas, Raymond Combs, Gregory Edwards, Hazel Betsy and Alliena Baker. In addition they recommended Mike Shriver, Ken Pearce and Gene London.

SS proposed *"a motion to amend the recommendation to include the names of the five members whose terms are about to expire."* Those members are *KB, MD, GG, NR,* and *KW.*

- **The council voted to approve the motion to amend the list of nominees.** [Attachment A, column 3]
- **The council voted to approve the nominations as amended.** [Attachment A, column 4]

ATTENDANCE REVIEW – VOTE

LCG reported that there were three members whose attendance was reviewed. The committee contacted *DB* who has an excused absence and plans to return to the council soon. They also spoke with *Virginia Cafaro* who is resigning from the council. The committee was unable to contact *LM. KW* suggested postponing a vote on the attendance review until next month. *JB* asked that an account be given of how many meetings members being reviewed have missed. *MJW* asked if HIV+ members were excused under any circumstances. *TC* said their excuses are based on medical need.

X. **Prioritization FY 2000-01**

Department of Public Health (DPH) Plan

Jimmy Loyce, Deputy Director, DPH, said the DPH is working on priorities for FY 2000-01 currently. Some of their goals are: to strengthen services for uninsured and under insured; to support community clinics; to build primary care while moving away from disease management at institutions such as San Francisco General Hospital (SFGH). He said the Health Commission has provided a mission statement. He said the DPH planning process is based on existing circumstances, and that the Welfare and Institutions code #17,000 establishes the basic strategy. He said the DPH is devising a schematic plan and timeline that will be in draft form by 11/99 and can be used to influence the priority process for FY2001-02. He said the DPH needs to know what the council's priorities are. *EW* informed *Jimmy* of the council's needs assessment that is currently underway, and said that would be a factor in the council's priority setting process this year. *LO'C* voiced concern about the proposed closure of Ward 4P at SFGH. *Jimmy* said that 4P would not be closed until there was an alternative. *LCG* asked if code 17,000 would be more open. *Jimmy* said the DPH has never had an overall plan, which he hopes will change with this priority setting process. *SS* emphasized the need for good providers if the DPH phases out the use of SFGH for HIV+ patients. She said the DPH must find community based service providers that will work with the city in caring for this population. She thought there need to be step-down facilities to get patients out of SFGH who don't need to be there. *TC* asked what the DPH could to support the council in its process. *Jimmy* said they could voice support of the council. The council asked *Jimmy* to return at another meeting for further discussion. He said he would.

XI. **PWA Caucus**

HIV CONSUMER RIGHTS ADVOCATE PROJECT – VOTE

- **The council voted to approve the job description for the HIV Consumer Rights Advocate.** [Attachment A, column 5]

XII. **Needs Assessment Report**

EW announced that 650 of 800 surveys are completed, and that all but one focus group are done. He said their meeting on 5/27/99 has been canceled. The next meeting date will be 6/2/99 from 5:30 to 7:30 PM. There will be a preliminary assessment report on 6/14/99 from 3-5:00 PM.

XIII. **Prioritization FY 2000-01**

CARE/REGGIE URS

Terry Dowling distributed a Reggie Data Review and gave an overview of what's driving Reggie (1) Client need; (2) HRSA required data; (3) Local planning. (4) Currently over 9,000 clients. She said 14 agencies currently use Reggie.

Anne Hirozawa said Reggie had nearly 6,000 clients in 1998 accounting for 40-45% of clients receiving CARE-eligible services in the SF EMA. 90% of Reggie clients chose to share information, and 75% had incomes under $10,000.

Rani Marx and *Justyn Lézin* reviewed questions asked of Reggie clients in 1998. There continue to be barriers to service and unmet needs. 1998 Reggie clients are similar to 1998 URS clients in

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age, gender, income level, homelessness, injection drug use, health insurance, and primary source of health care. At least 35% of clients went without needed services in the past six months. Homeless and transgendered clients appear to have higher unmet need than other clients do. . *TC* suggested the questions being asked be reconsidered.

HIV/AIDS PREVALENCE
Laura Thomas, AIDS Office, distributed:

- HRSA's Using Data to Assess HIV/AIDS Service Needs
- San Francisco HIV Epidemiology Report
- Quarterly AIDS Surveillance Report through March 1999
- Annual AIDS Surveillance Report 1998
- 13 charts on San Francisco AIDS statistics
- HAB Policy Notice – 99-02 The Use of Ryan White CARE Act funds for Housing Referral Services and Short-term or Emergency Housing Needs

XIV. **New Business**
None

XV. **Adjourn**
8:30 PM

The Council meets on the fourth Monday of each month, at the time and place noted on the agenda. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 863-5462. The closest accessible BART station is Civic Center. Accessible MUNI lines serving this location are: #42 Downtown Loop, #71 Haight/Noriega, #9 San Bruno, F Line to Market and Van Ness, and Metro Van Ness station. For more information about MUNI accessible services, call 923-6142. *Minutes of meetings are tentative until formally approved by the Council.*

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HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

5/24/99		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	*KB*	E											
Dorothy Bartolomucci	*DB*	L											
Donald Bliss	*DCB*	P	N	Y	Y	Y							
Chris Boehm	*CB*	E											
Jeff Byers	*JB*	P	Y	Y	Y	Y							
Virginia Cafaro	*VC*	A											
Tom Calvanese	*TC*	P	Y	Y	Y	Y							
Bart Casimir	*BC*	P	Y	Y	Y								
Veronika Cauley	*VC*	E											
Julie Charubusapayon	*JAC*	A											
John Conley	*JC*	P	Y	Y	Y	Y							
Luis De La Torre	*LDT*	P	Y	Y	Y	Y							
Mark Dunlop	*MD*	E											
Gene Gowdey	*GG*	P	Y	B	B	Y							
Laura Guzmán	*LCG*	P	Y	Y	Y	Y							
Siddiq Jihad	*SJ*	P	Y	Y	Y								
Darrell Joe	*DCJ*	A											
Diane Jones	*DJ*	E											
Samuel Kaplan	*SK*	P	Y	Y	Y	Y							
Tony Leone	*TL*	E											
Allen Meyer	*AM*	P	Y	Y	Y	B							
Lee Ann Monfredini	*LM*	A											
Norm Nickens	*NN*	E											
Lisa O'Connor	*LO'C*	P	Y	Y	Y	Y							
Loras Ojeda	*LO*	P											
Jorge Ortiz	*JO*	P	Y	Y	Y	Y							
Stephan Oxendine	*SO*	P	Y	Y	Y	Y							
Alissa Riker	*AR*	A											
Nilda Rodriguez	*NR*	P	Y	Y	Y	Y							
Matthew Sharp	*MS*	P	Y	Y	Y	Y							
Susan Shea	*SS*	P	Y	Y	Y	Y							
Kelly Wallace	*KW*	P	B	B	B	Y							
Eric Whitney	*EW*	P	Y	Y	Y	Y							
Mary Jane Wood	*MJW*	P	B	Y	Y	Y							

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

HIV/AIDS Bureau

Health Resources and
Services Administration
Rockville MD 20857

HAB POLICY NOTICE - 99-02

Document Title: **The Use of Ryan White CARE Act funds for Housing Referral Services and Short-term or Emergency Housing Needs**

DATE: MAY 11 1999

TO: All Ryan White CARE Act Grantees

Enclosed is the HIV/AIDS Bureau (HAB) policy describing the use of Ryan White CARE Act funds for housing referral services and short-term or emergency housing needs. Funds designated to carry out the provisions of Section 2616 of the Public Health Service Act may be used to fund housing and related services under certain conditions, as described.

If you have any questions regarding the content of the HAB Policy Notice, please contact your project officer. Thank you for your attention to this important matter.

Joseph F. O'Neill, M.D., M.P.H.
Associate Administrator

Enclosure

D. The Ryan White CARE Act must be the payer of last resort. In addition, funds received under the Ryan White CARE Act must be used to supplement but not supplant funds currently being used from local, State, and Federal agency programs. Grantees must be capable of providing the HIV/AIDS Bureau with documentation related to the use of funds as payer of last resort and the coordination of such funds with other local, State, and Federal funds.

E. Ryan White CARE Act housing-related expenses are limited to Titles I, II, and IV and are not an allowable expense for Title III.

HIV HEALTH SERVICES PLANNING COUNCIL

June 28, 1999 4:30 - 7:30 PM

Room 201 - City Hall - 1 Dr. Carlton B. Goodlett Place

Agenda

I.	Call to Order	4:30 PM
II.	Roll Call	4:32 PM
III.	Review and Approval of Agenda	4:34 PM
IV.	Review and Approval of Minutes from 5/26/99 - VOTE	4:35 PM
V.	General Announcements	4:40 PM
VI.	Public Comment	4:45 PM
VII.	Mayor's Liaison Report – Bill Barnes	4:55 PM
VIII.	Co-chairs Report	5:00 PM
IX.	Membership Committee	5:05 PM
	• Recommendation of new members - VOTE	
	• Attendance Review – VOTE	
X.	Prioritization Timeline for June/July/August	5:15 PM
XI.	Request for rollover of unliquidated FY 98-99 funds from HRSA -VOTE	5:25 PM
	Break (10 minutes)	5:55 PM
XII.	Needs Assessment presentation	6:05 PM
XIII.	New Business	7:25 PM
XIV.	Adjourn	7:30 PM

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JUN 23 1999

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06-23-99A10:33 RCVD

SF Dept. of Public Health — AIDS Office, 25 Van Ness, 5th floor
City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council Members, are available for inspection and copying. For further information, call the Council's staff, 415-863-5462. The closest accessible BART Station is Civic Center. Accessible MUNI lines serving these locations are #42 Downtown Loop, #71 Haight/Noriega, #9 San Bruno, F Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 923-6142. *Minutes of Meetings are tentative until formally approved by the Council.*

HIV Health Services Planning Council

Memo

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JUN 23 1999

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To: Council members

From: Michael Moors

Date: 6/21/99

Re: Posting agendas

I have been informed by Terry Gwiazdowski, San Francisco Documents Librarian, that in order to comply with city regulations regarding Open Meeting laws and the Sunshine Ordinance, that are part of the San Francisco Administrative Code, the Council is required to provide a description of what is to be discussed at each meeting, in addition to the meeting date, time, and place which are being posted.

I propose that a brief list of upcoming agenda items be included in the minutes of each meeting that, along with the next meeting information, could be used to create the required document for posting.

I welcome any suggestions regarding this subject.

Example of proposed posting document

DATE/TIME	PLACE	GROUP	AGENDA
7/6/99 5:30-7:30 PM	25 Van Ness Ave Rm. 330-A	Membership Committee	• Review applications • Poll members on consumer representation • New member orientation

All CARE Council & Committee meetings are held in accessible sites, and are open to members of the public. Participation of people living with HIV is strongly encouraged. The public will be allowed to comment on every item on the agenda, regardless of whether it is an action item Minutes of meetings and all information distributed to Council members are available for public inspection and copying. For further information contact Council staff at 415/863-5462

The following is taken from an OVERVIEW OF OPEN MEETING LAWS from the Office of the City Attorney.

AGENDA REQUIREMENTS

Posting Requirements

The agenda must be posted in a location freely accessible to the public. San Francisco has designated the Main Library as its official posting site. In addition, the agenda should be posted at the commission's office and meeting site.

For regular meetings, the agenda must be posted at least 72 hours before the meetings. For special meetings, the agenda must be posted at least 24 hours before the meeting.

Content

Each agenda must contain a brief general description of each item of business the commission will consider, whether or not it intends to take action on the item. The description must be "sufficiently clear and specific to alert a person of average intelligence and education whose interests are affected by the item that he or she may have reason to attend the meeting or seek more information on the item." In addition, the agenda must inform the public that it will be allowed to comment on every item on the agenda, regardless of whether it is an action item.

Action under the agenda

Generally, a commission may only act on or discuss items that have been posted on the agenda. Commission members may, however, respond o statements made or questions asked by the public. Commissioners must take care to ensure that their responses do not become a discussion of the issue. In addition, under very limited emergency circumstances, a commission may act on items not listed on the agenda. If this problem arises, please contact the City Attorney's Office for assistance.

SUPPORT CENTER
FOR NONPROFIT MANAGEMENT

Nonprofit Development Center

San Francisco Office
706 Mission Street
5th Floor
San Francisco
CA 94103-3113
415-541-9000 ph
415-541-7708 fx

San Jose Office:
1922 The Alameda
Suite 212
San Jose
CA 95126-1430
408-248-9505 ph
408-248-9504 fx

Email:
supportcenter@supportcenter.org

World Wide Web:
http://www.supportcenter.org/sf
http://www.genie.org

TO: Members of the HIV Health Services Planning Council
FROM: Gary Levinson GL
Project Manager, 1999 HIV Client Needs Assessment
DATE: June 21, 1999
RE: Qualitative Sampling and Methodology

In preparation for the presentation to the Planning Council on June 28, my team and I are sending you information about the population sampled, its demographics, and the methodology for the qualitative components of the Needs Assessment. These components include the Focus Groups and the Medical Provider Surveys.

Please review these documents before the meeting. Because the agenda is so full, we will not have the opportunity to present this information to you at the meeting. The meeting agenda will focus instead on the Needs Assessment findings. We hope that the enclosed information will help you to prepare for the important process of prioritization and CARE services funding allocation.

We look forward to seeing you on June 28.

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1999 HIV Client Needs Assessment
Focus Groups

Methodology

This component of the 1999 HIV Client Needs Assessment is a qualitative study of client experiences of HIV Health Services in San Francisco and San Mateo. The emphasis of the study is on client need, unmet need, and barriers to meeting identified need. However, because of the qualitative nature of the study, general themes of client experience with the system of care and the quality of services emerged as well. The data was collected in a series of 22 focus groups, both population specific and mixed demographic. The following is a summary of the methodology used in this study.

The Sample

Consultants from the Support Center for Nonprofit Management worked with the HIV Health Services Planning Council Needs Assessment Task Force to identify the populations for each of the 22 focus groups. Several factors played role in the selection of focus group populations. It was essential to balance the Council's interest in gathering data on particular populations with collecting information on as wide a diversity of experience as possible. In addition, the selection process also took into account the population sample for the quantitative client survey component of the assessment which included over-sampling of some populations of special interest.

The 22 focus group populations agreed on by the Task Force are as follows:

1. Gay and Bisexual African-American Men
2. African-American Men (Straight)
3. African-American Women
4. Gay and Bisexual Latinos
5. Latino/as, monolingual
6. Latinas
7. Youth (16-23)
8. Incarcerated – Jails
9. Former Incarcerated - Parolee
10. Native American
11. Asian/Pacific Islander – Established and Recent Immigrants (English-speaking)
12. Filipino (from San Francisco and North San Mateo)
13. Transgender
14. Gay and Bisexual White Men
15. Men Who Have Sex with Men and Injection Drug Users
16. Mixed Demographic Injection Drug Users
17. Women and Women with Children
18. Homeless/Marginal Housing/PLWH who receive Medical Care in the Emergency Room

19. Mixed Demographic (pilot)
20. Mixed Demographic
21. Mixed Demographic
22. San Mateo
23. San Mateo

Because of scheduling difficulties, the incarcerated focus group has yet to be conducted. However, a third mixed demographic group was conducted as a pilot for group process and questions. Data from this mixed demographic group is included in the study.

Research Team

In a qualitative study such as this, the expertise and diversity of the facilitators is essential. The research team was involved in the construction of the focus group questionnaire, in the facilitation of the groups, and in the analysis of the data. The team consisted of a project manager/facilitator; four facilitators, and two logistical coordinators. The facilitators included a white gay man living with HIV; an Asian gay man living with HIV; an African-American gay man; an African-American lesbian; and a heterosexual Latina. All had significant experience in working within the HIV community as well as having diverse professional backgrounds (management, law, education, social service, community organizing, and counseling). The entire project was overseen by the Director of Consulting.

Recruitment

Clients were recruited to reflect the diversity of people living with HIV in terms of age, gender, race, ethnicity, sexual behavior, and drug use, including homeless individuals, people receiving medical care in emergency rooms, and those who were formerly incarcerated. Group members were recruited in a variety of ways to ensure both adequate participation and the randomness of the sample. Three basic strategies were used.

- General Recruitment: Each Council Member was provided with a set of flyers for distribution throughout the community. Council members were asked to post the flyers at agencies or to hand them directly to people with HIV.

- Specialist Recruitment – Recruitment Specialists were hired to distribute flyers on-site in waiting rooms, group meetings, drop-in centers, on the street, or any place where people with HIV appropriate to the population groups congregate. Specialists were responsible for personally encouraging people to participate.

- Targeted Recruitment – Some Recruitment Specialists were paid to recruit a specific number of participants for a specific population group, such as 6 African-American Gay or Bisexual Men.

For General and Specialist Recruitment, people with HIV interested in participating were asked to call the Support Center. The Logistical Coordinators then asked them a few questions in order to slot them into the appropriate group. For Targeted Recruitment, Specialists called the Support Center directly to sign up these participants for the appropriate group. Council Members and/or Recruitment Specialists were not eligible to be participants in the Focus Groups. In addition, participants could attend only one group.

Data Collection

The purpose of this study is to identify the needs of low/no income people living with HIV, the needs that are met by the current system of care, and the barriers that keep people from accessing the services that would meet their needs. In order to investigate these themes, each group was asked a series of twenty-two specific questions in six major categories:

- How does HIV affect your health now?
- Current treatments
- Current Service Usage
- Access to Services
- Entry or Return to Work
- Vision for a better HIV Health Services system in the future.

The focus group instrument was created and revised by the project manager and facilitators with the supervision and final approval of the Needs Assessment Task Force.

A total of 194 clients of the HIV Health Services System in San Francisco and San Mateo participated in the twenty-two focus groups. The following procedures were used to ensure the success of the groups and the integrity of the data.

- All facilitators were involved in development of the focus group instrument and attended the test group. Guidelines for the groups were distributed and discussed among the facilitators.

- In most cases, population-specific groups were conducted by a facilitator having cultural and demographic characteristics similar to the participants. For example, the groups targeting African Americans with HIV were conducted by an African American facilitator. One focus group was conducted in Spanish. The Filipino group was conducted primarily in Tagalog by a special bi-lingual facilitator.

- Focus groups were held at several different sites throughout San Francisco and San Mateo to provide participants with convenient and comfortable locations and to reflect cultural choices and desires for confidentiality. Groups were conducted on different days of the week and at different times of the day to accommodate a variety of participant schedules.

- Immediately following each group, participants completed a Client Demographic Survey, an instrument similar to that completed by the quantitative Client Survey participants.

- Complete confidentiality was insured for all clients participating in the study.

- Clients were paid an incentive of $25 cash for their participation. Snacks and non-alcoholic beverages were provided at each group.

- All focus groups were audio tape-recorded. A complete written transcript of the proceedings was developed for each group with the exception of the monolingual Spanish group and the bilingual Filipino group. These groups were partially transcribed by the facilitators.

Analysis

In the analysis of the data, it was essential to limit the potential for bias and to faithfully interpret the attitudes and opinions of the participants. In order to ensure this, the analysis included both individual and group examination. The following processes were utilized.

Theme Identification: Facilitators identified the primary common themes for each group they facilitated in the six major topic areas listed above. Facilitators completed a topic area template as soon as possible after each focus group. Because this is a client needs assessment, client NEEDS and BARRIERS to getting their needs met were the most essential themes to be identified. However, the qualitative data derived from these focus groups allows findings to be more broadly based: to include client perceptions about quality of care and the efficacy of the service delivery system.

Individual Analysis: Facilitators reviewed the transcriptions of each of the focus groups they led. The review concentrated on the following three theme types:

- Primary themes – client needs, unmet needs, and barriers to getting those needs met as well as findings that were common across focus groups.
- Secondary themes – more subtle underlying themes that may require extrapolation from what is "unsaid" in a group. These may have more to do with client feelings and the community environment. They may be common to one or more than one of the groups.
- Counter themes – two types may emerge: outlyers which are noticeably important to a small number of people in the group and those which run against the grain of the more common primary and secondary themes.

All themes were supported with quotes from the transcripts.

Shared Group Analysis: The facilitators held a series of meetings to share their findings with each other. In the first meeting, facilitators compared their individual findings. Discussion focused on developing Primary and Secondary common themes across all groups; Primary and Secondary themes that may be related to demographics; and common Counter themes. The goal of this meeting was consensus on the Primary themes (with supportive quotes) to be presented in the final report. At the end of the meeting, facilitators received a copy of *Voices of Experience* to review before the next meeting.

In the second meeting, facilitators compared the findings of the current study those of 1994's *Voices of Experience.* Comparison concentrated on Seven Requirements for a Client-Centered System of Care and Implications for Service Delivery and Planning. The requirements are a mix of Primary and Secondary themes. Analysis from the first meeting also continued. Subsequent meeting concentrated on further development of the themes and organizing the findings.

Cross-Analysis: Finally, staff from all components of the Needs Assessment participated in cross-analysis from all components of the Needs Assessment: Client Survey, Focus Groups, and Medical Provider Interviews. The quantitative results of the survey provided the foundation for the assessment. The staff compared qualitative findings with quantitative findings. Based on this comparison, the group formulated conclusions and recommendations for the Council to consider in their prioritization and general planning.

Presentations: Data from all components of the Needs Assessment was presented to the Task Force on June 14. The Task Force also reviewed the conclusions and draft recommendations. After this meeting, the presentation of data and recommendations were finalized. The final presentation is scheduled for the CARE Council meeting on June 28. The final product of the Needs Assessment will be a document that includes the findings of each component and the recommendations based on the cross-analysis. This Final Report will be delivered to the CARE Council on July 12.

HIV CLIENT NEEDS ASSESSMENT

FOCUS GROUP DEMOGRAPHICS

Gender

Male	129
Female	39
TG	24
Blank	2

Sexual Orientation

Gay/Homosexual	80
Heterosexual	61
Bisexual	31
Other/Blank	10
Don't know	7
Unsure	3
Lesbian	2

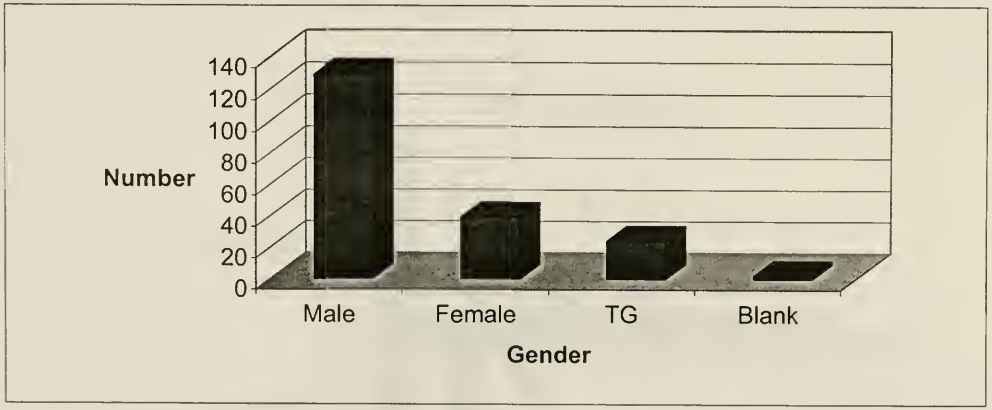
Racial/Ethnic Background

African-American	77
European-American/White	46
Latino/a	27
Asian/Pacific Islander	21
Native American	11
Other	9
Mixed	3

HIV CLIENT NEEDS ASSESSMENT

GENDER

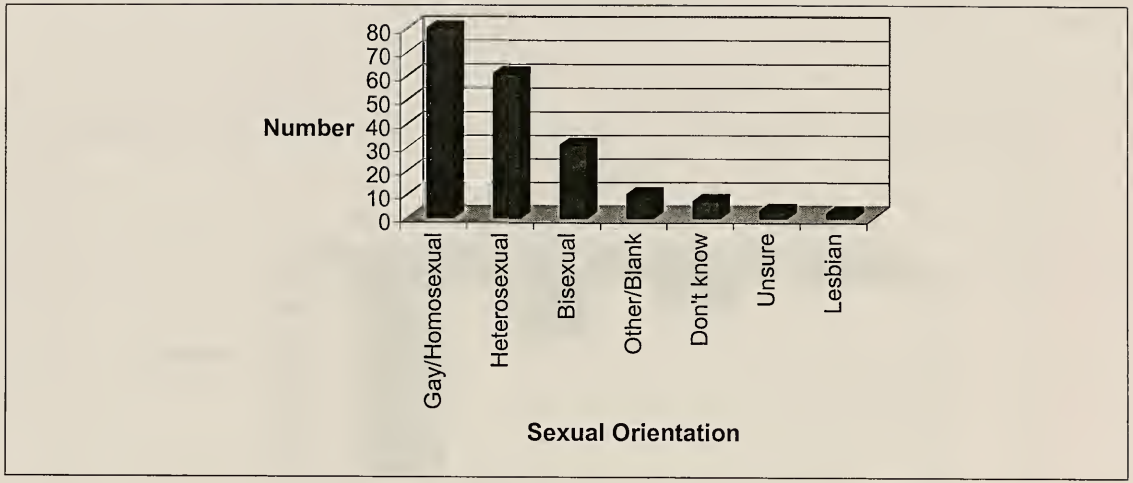
Male	129
Female	39
TG	24
Blank	2



HIV CLIENT NEEDS ASSESSMENT

SEXUAL ORIENTATION

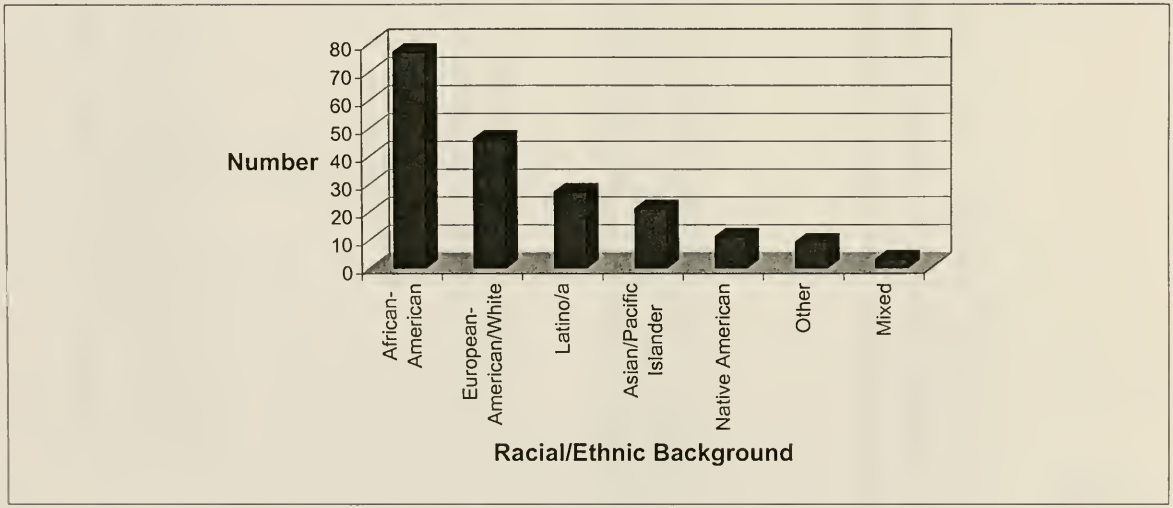
Gay/Homosexual	80
Heterosexual	61
Bisexual	31
Other/Blank	10
Don't know	7
Unsure	3
Lesbian	2



HIV CLIENT NEEDS ASSESSMENT

RACIAL/ETHNIC BACKGROUND

African-American	77
European-American/White	46
Latino/a	27
Asian/Pacific Islander	21
Native American	11
Other	9
Mixed	3



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Down in the "Clinical Trenches": A Needs Assessment Study of Health Service Providers at CARE-funded Agencies in San Francisco

Presented to the HIV Health Services Planning Council
of the San Francisco Eligible Metropolitan Area
and the San Francisco Department of Public Health AIDS Office

R. Ruth Linden, Ph.D.
University of California, Berkeley

June 1999

Prepared in consultation with Petra Liljestrand, Ph.D.
Community Providers AIDS Training Project
San Francisco General Hospital Medical Center and
Gary Levinson, M.A.
Support Center for Nonprofit Management/NDC

I. Introduction: Design and Methodology

The HIV Services Planning Council (hereafter referred to as the Planning Council) is required by the Ryan White CARE Act to undertake periodic needs assessments to determine the needs of people living with HIV/AIDS in the San Francisco EMA. Accordingly, the AIDS Office contracted with the Support Center for Nonprofit Management/NDC to conduct both the client/patient and provider components of the project. At the Support Center, Gary Levinson, Director of HIV Special Projects, subcontracted with Dr. R. Ruth Linden to conduct the provider component.[1] Dr. Petra Liljestrand consulted with the project team on an as-needed basis.[2]

The study was designed to interview 35 providers. Dr. Kirsten Balano,[3] Co-chair of the Planning Council's Needs Assessment Task Force assumed responsibility for identifying study participants; and along

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[1]Consultant and medical sociologist, Beatrice M. Bain Research Group, University of California, Berkeley.

[2]Program Evaluator, Community Provider AIDS Training Project, San Francisco General Hospital.

[3]Director of Drug Information, Community Provider AIDS Training Project, San Francisco General Hospital.

with her colleagues, Susan Shea, FNP[4] and Dr. Ronald Goldschmidt,[5] contacted individual providers and invited them to participate in the study. All providers who were contacted agreed to be interviewed. With several exceptions, each interview was completed in 30 to 40 minutes. The interview schedule is included in the appendix of this report.

After approximately 20 interviews had been conducted, it appeared that the data were saturated. The Needs Assessment Task Force agreed to freeze the sample size at 25; and, at this time, it requested that between three and five interviews be conducted with CARE-funded complementary providers. Subsequently three acupuncturists were interviewed, which brought the final sample size to 28. The sample is described in the next section of this report.

Thorough transcripts of the interviews were prepared. Sample demographics were coded and emergent themes in the data were identified and analyzed. Based on this analysis eight recommended action steps were developed that address the study's key findings about service gaps and barriers.

---

[4]Member, HIV Health Services Planning Council and primary care provider at the UCSF Positive Health Program.

[5]Director, Community Provider AIDS Training Program, San Francisco General Hospital.

II. Description of Sample

The findings presented in this report are based on interviews conducted with a convenience sample of 28 medical and complementary providers at CARE-funded agencies in San Francisco. Female providers in this study (n=18) outnumber their male colleagues (n=10) by a ratio of nearly 2 to 1. It is not known to what degree the gender composition of the sample resembles that of the CARE provider community in San Francisco. See Figure 1.

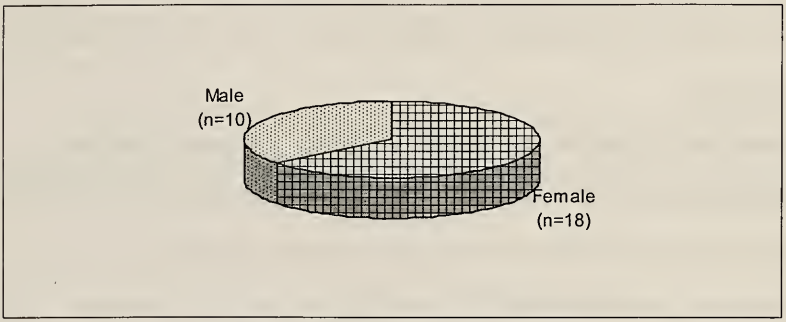

Figure 1: Composition of the Sample by Gender

Physicians (n=12) are the largest provider group in the study, followed by nurse practitioners (n=8). Other professions represented are: acupuncturist (n=3), physician's assistant (n=2), registered nurse (n=2), and clinical social worker (n=1).[6] See Figure 2

[6]This provider was interviewed at the request of the medical director of the clinic where he coordinates mental health services.

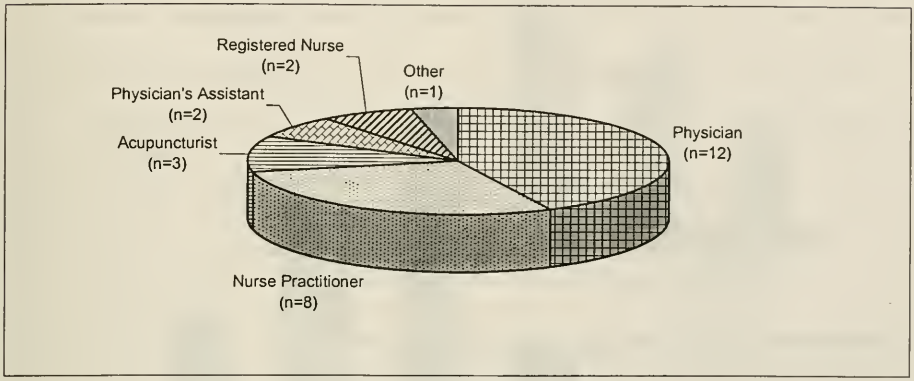

Figure 2: Composition of the Sample by Profession

HIV primary care providers (n=18) represent the largest group of practitioners, while complementary providers who practice acupuncture and Chinese herbal medicine (n=3) are the smallest group. HIV specialists in obstetrics (n=2), gynecology (n=2), and psychiatry and mental health (n=2) were also interviewed. See Figure 3.

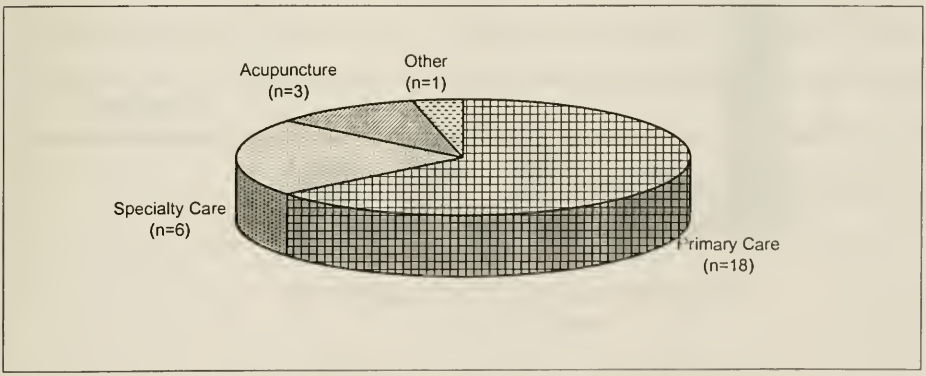

Figure 3: Composition of the Sample by Scope of Practice

On the whole, our respondents are highly experienced providers of HIV/AIDS care. Almost 20% (n=5) have been working in the epidemic for at least 16 years. Fifty percent (n=14) has been providing HIV care for at least 11 years, while 80% of the group (n=23) has more than five years of experience with HIV clients, as shown in Figure 4.

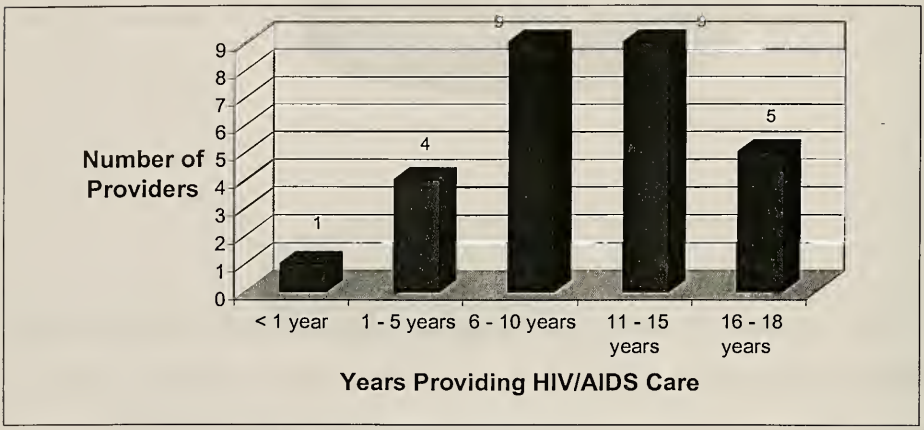

Figure 4: Years Providing HIV/AIDS Care

The practitioners we interviewed carry heavy patient-care responsibilities. The majority of the sample (n=23) is in clinic at least 40% of the time, and nearly 20% (n=5) sees clients at least four days per week. Only one respondent spends less than one day each week with clients; just four providers provide hands-on care fewer than two days per week. See Figure 5.

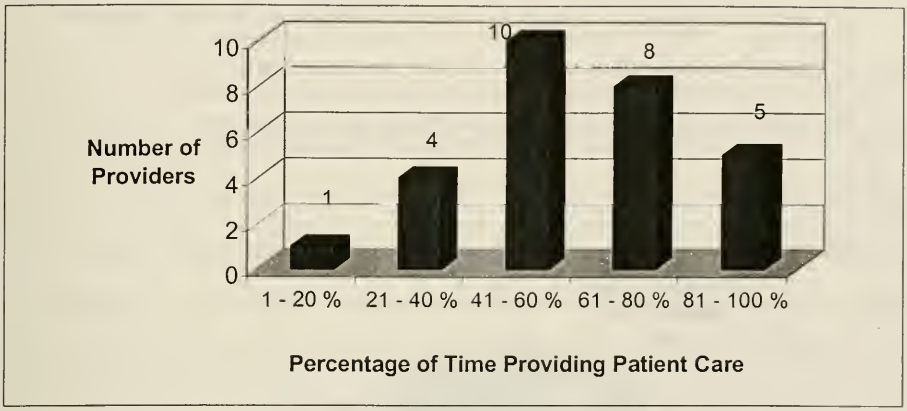

Figure 5: Percentage of Time Providing Patient Care

These providers' schedules are made all the more formidable by the proportion of clinical time they spend providing HIV care. More than 70% of our respondents (n=20) spend at least 60% of their clinic time with HIV/AIDS clients. Fewer than 30% (n=8) spend 40% or less of their time in clinic with HIV clients, as shown in Figure 6.

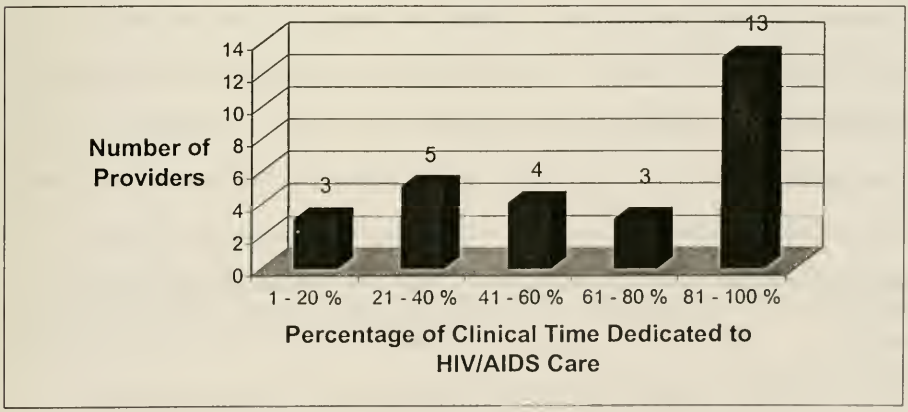

Figure 6: Percentage of Clinical Time Dedicated to HIV/AIDS Care

More than half of the respondents we interviewed (n=15) see their clients at U.C. San Francisco/San Francisco General Hospital, while independent clinics *not* affiliated with the San Francisco Department of Public Health comprise just under 30% (n=8) of the work sites. Just under 20% (n=5) of the providers work at Community Health Network (CHN) clinics, which *are* affiliated with the Department of Public Health. See Figure 7.

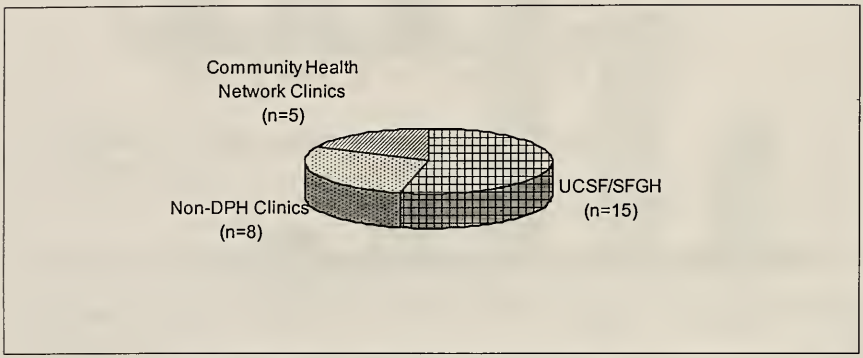

Figure 7: Clinical Sites Represented in the Study

Limitations of the sample The small number of providers we interviewed and the need, based on resource and time constraints, to select a convenience sample prevent us from making generalizations about our findings beyond the subpopulation that participated in this study. We do not know whether or to what degree the population of HIV medical and complementary CARE providers in San Francisco is represented in this study. Provider characteristics that may be over- or underrepresented include: ethnicity, gender, profession, scope of practice, experience providing HIV care, and sector of practice (tertiary, public health, or nonprofit).

However, with this caveat in mind, we can say with confidence that the data are saturated, that is, successive respondents provided the same or similar responses to a significant number of questions. This

suggests that the data reflect the range of views on a given topic—that most of what there is to say has been said—and that there is probably a high degree of consensus on numerous issues.[7] Thus, while the construction of the sample does not permit us to say that our findings are representative or "significant" in the statistical sense, we are confident that this report identifies many—if not most—of the CARE provider community's pressing concerns. In combination with clear trends in the data, our understanding of access barriers typically encountered by low-income and medically underserved people and of demographic trends in San Francisco and other cities hit earliest and hardest by the HIV epidemic provides assurance that the study's findings have important implications for the development of CARE program priorities.

[7]This research was not designed to determine the percentage of respondents who identified *this* problem as a significant barrier to access or *that* gap in CARE-funded services. Instead, the aim was to describe general trends that emerged in the data.

HARDER + COMPANY COMMUNITY RESEARCH

MEMO

To: Council Members
From: Harder+Company Community Research
Subject: Survey Findings
Date: June 21, 1999

On Monday, June 28th, results of the San Francisco EMA Needs Assessment Health Services Survey will be presented to the Council. The presentation will cover met and unmet service need for the ten service categories assessed in the study. Due to limited time for the presentation, demographic characteristics of the survey sample are being sent to you in advance for your review. These findings will not be included in the presentation. There will be time to address your questions regarding these findings at the end of the presentation.

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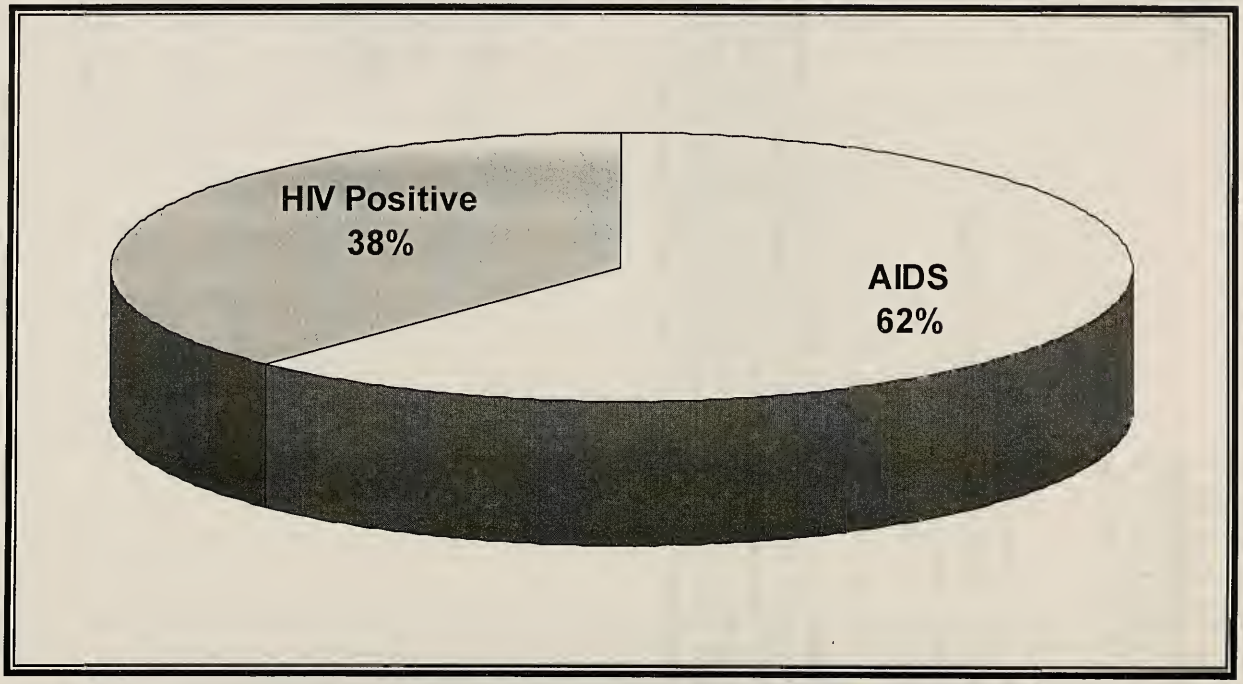
From the desk of...

Michael DeMayo
Senior Research Associate
Harder + Company Community Research
444 DeHaro
San Francisco, CA 94107

415.522.5400
Fax: 415.522.5445

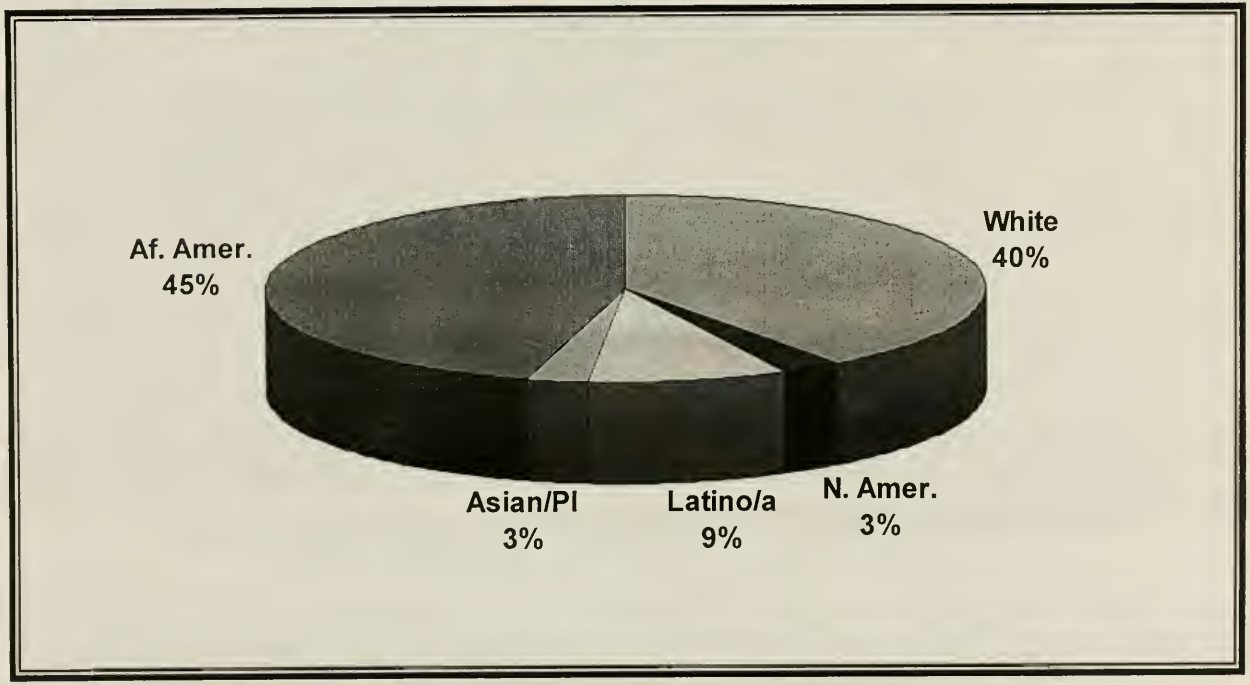
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

HIV Status (n=968)



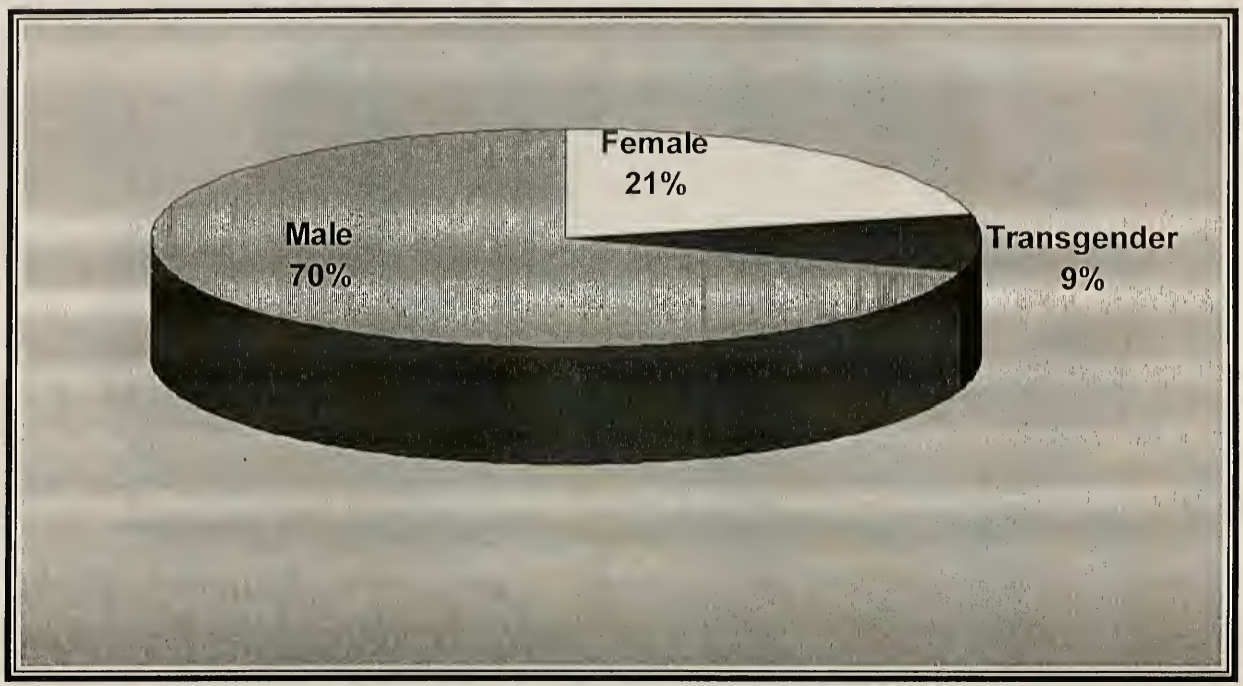
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Ethnicity (n=968)



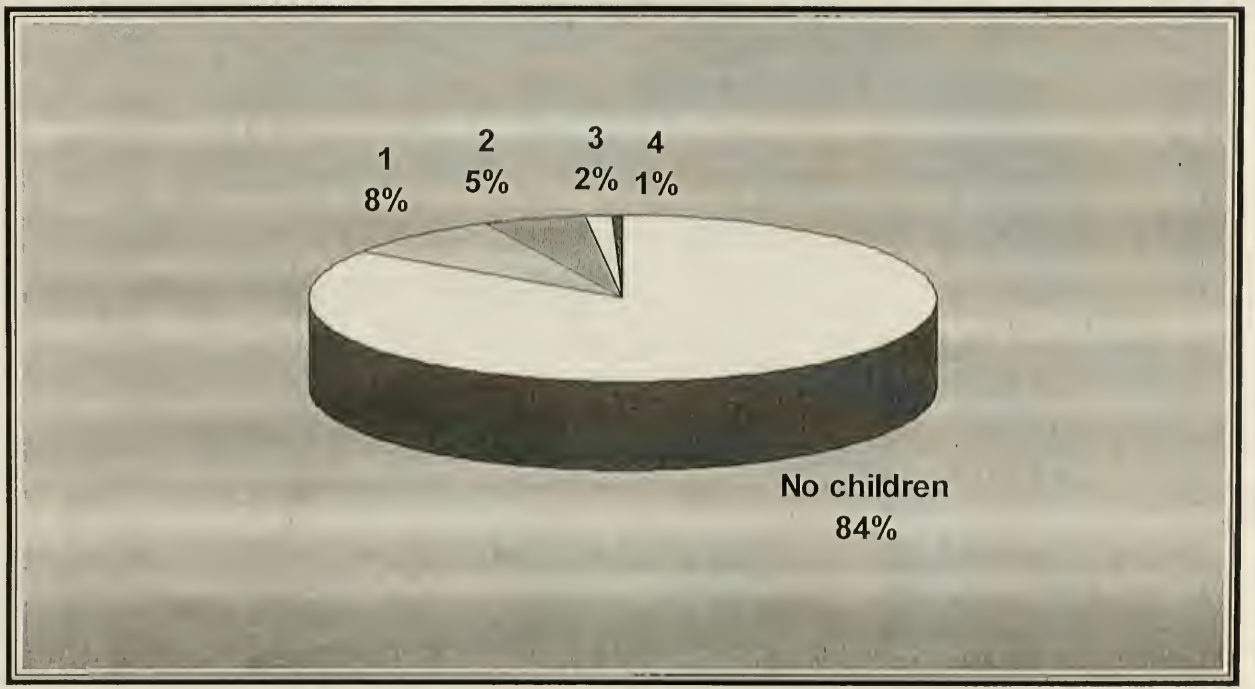
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Gender (n=968)



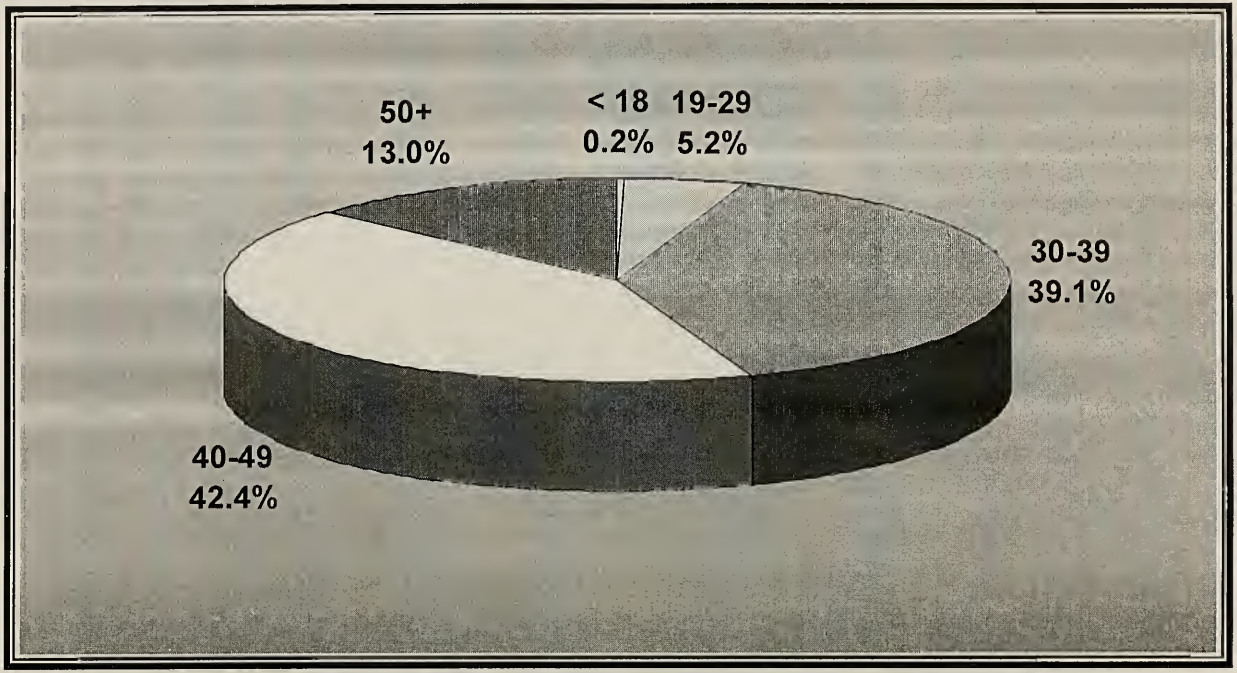
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Women with children (n=206)



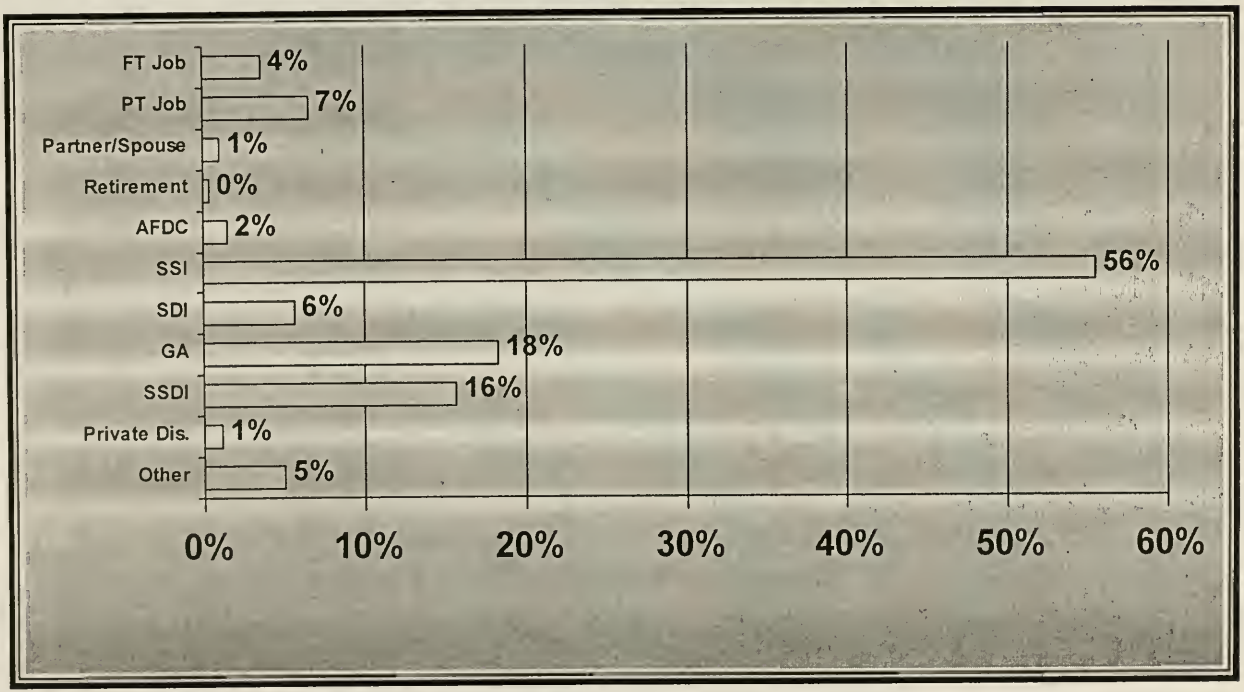
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Age (n=968)



A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Source of Income (n=968)



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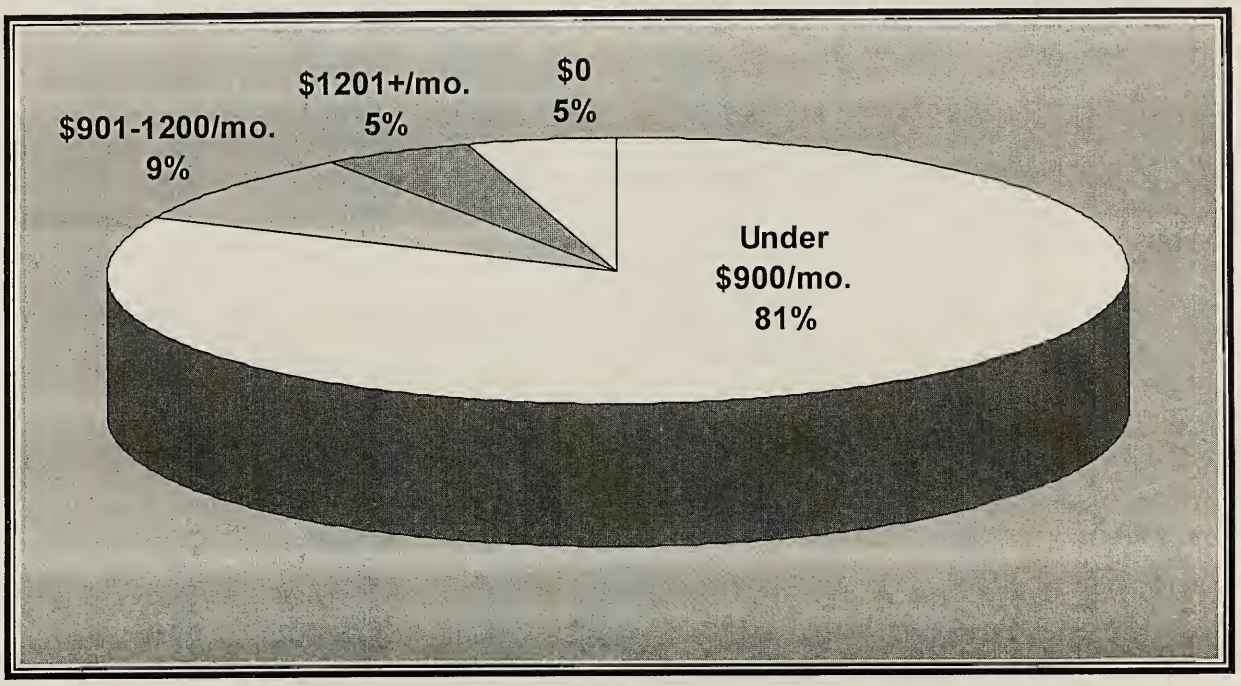
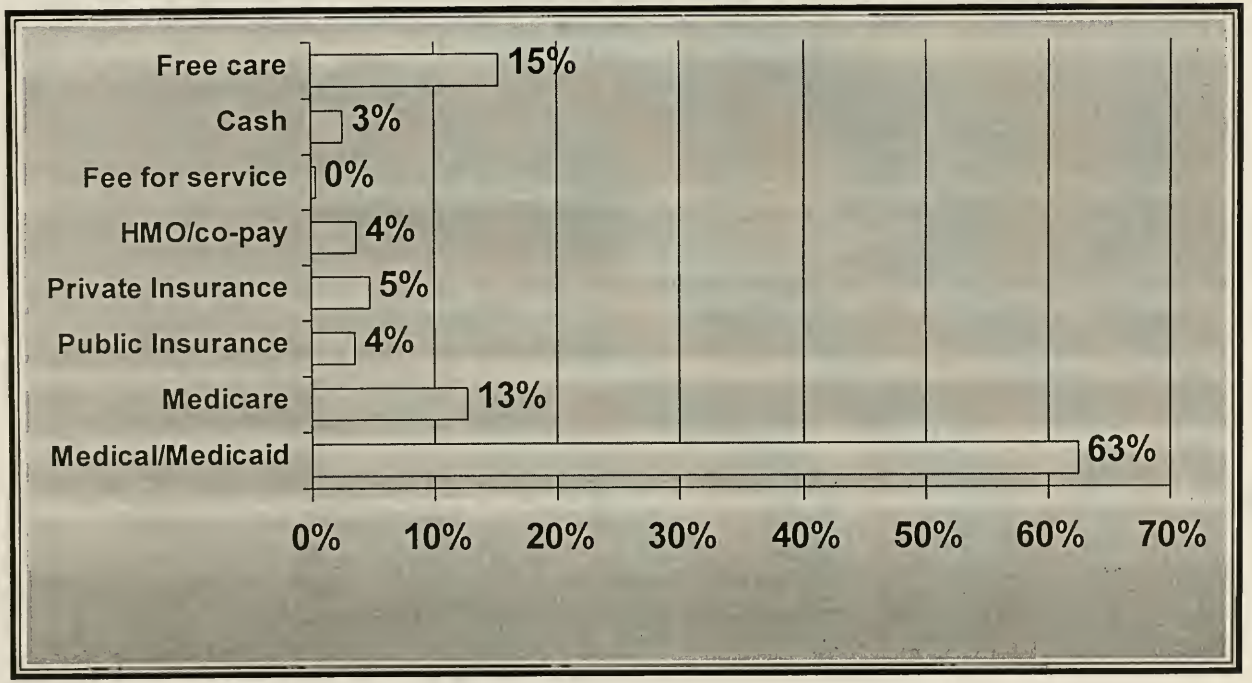
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Income (n=968)



A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Insurance Status (n=968)



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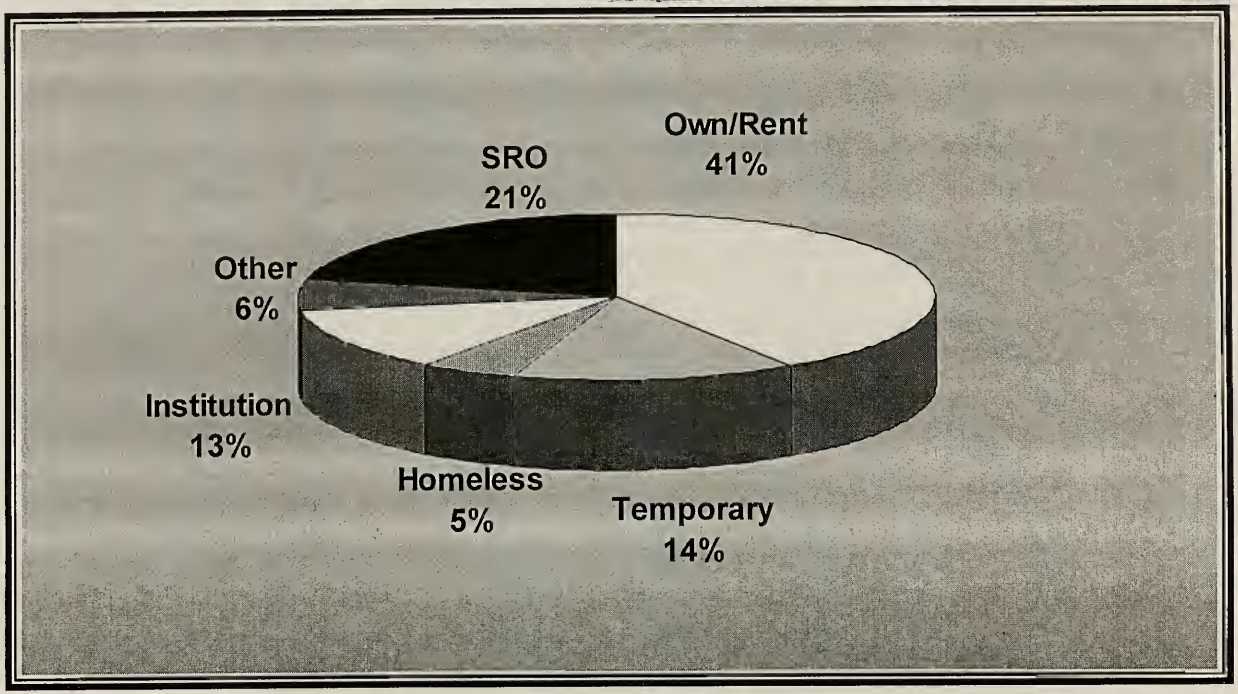
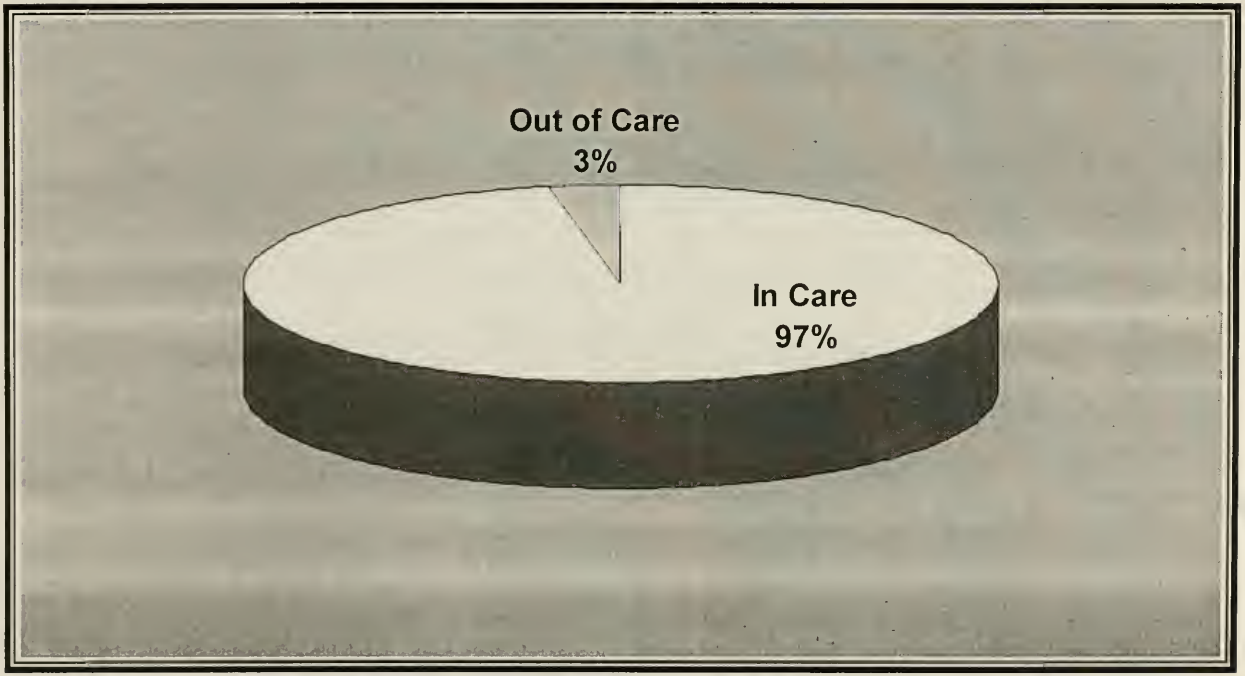
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Housing Status (n=968)



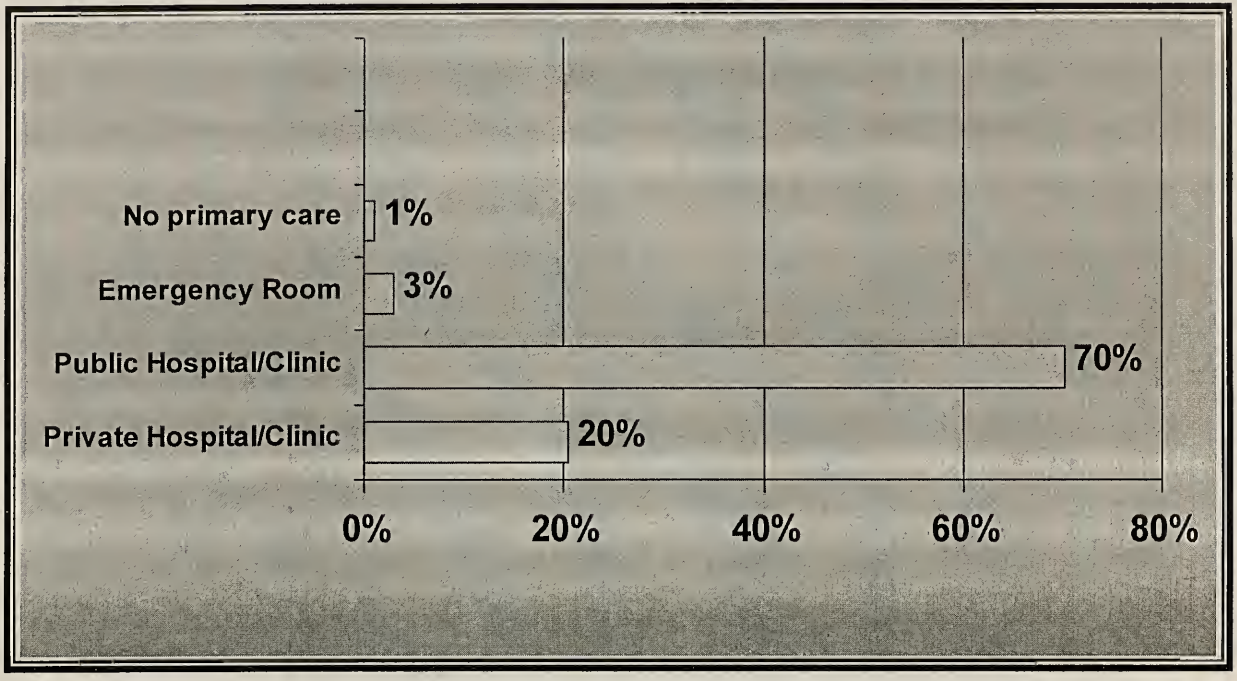
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

In and Out of Care (n=968)



A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Where people get their health care (n=968)



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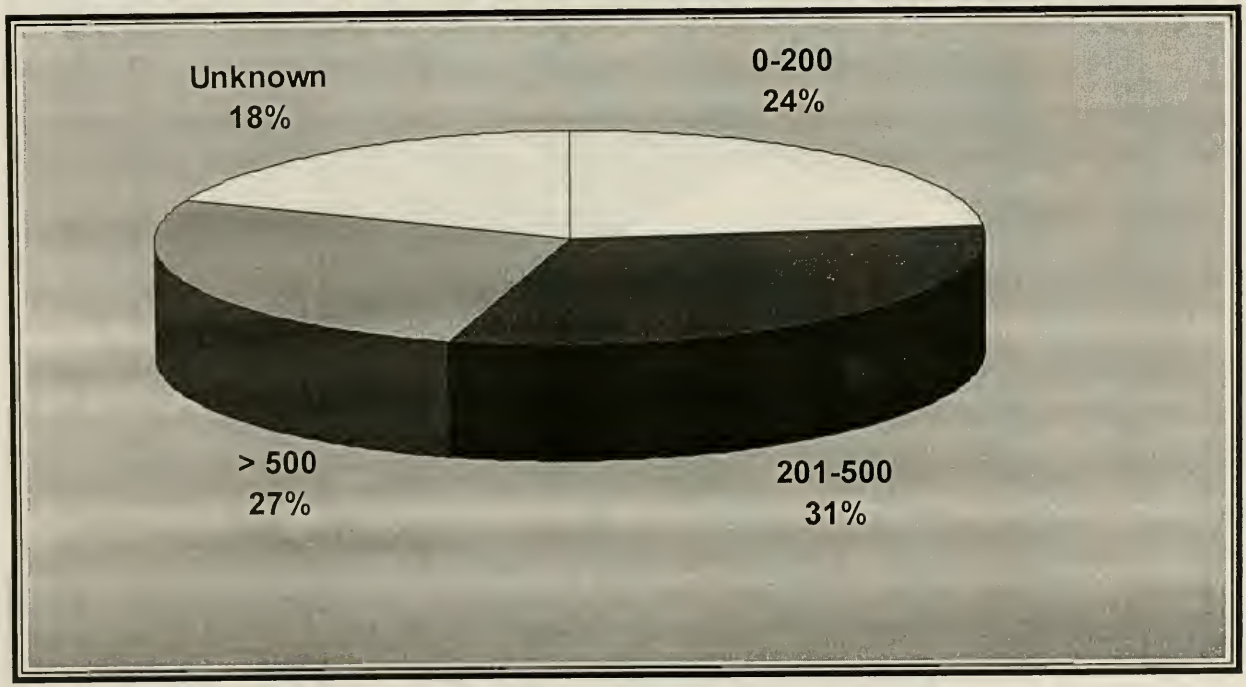
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

CD4 Count (n=968)



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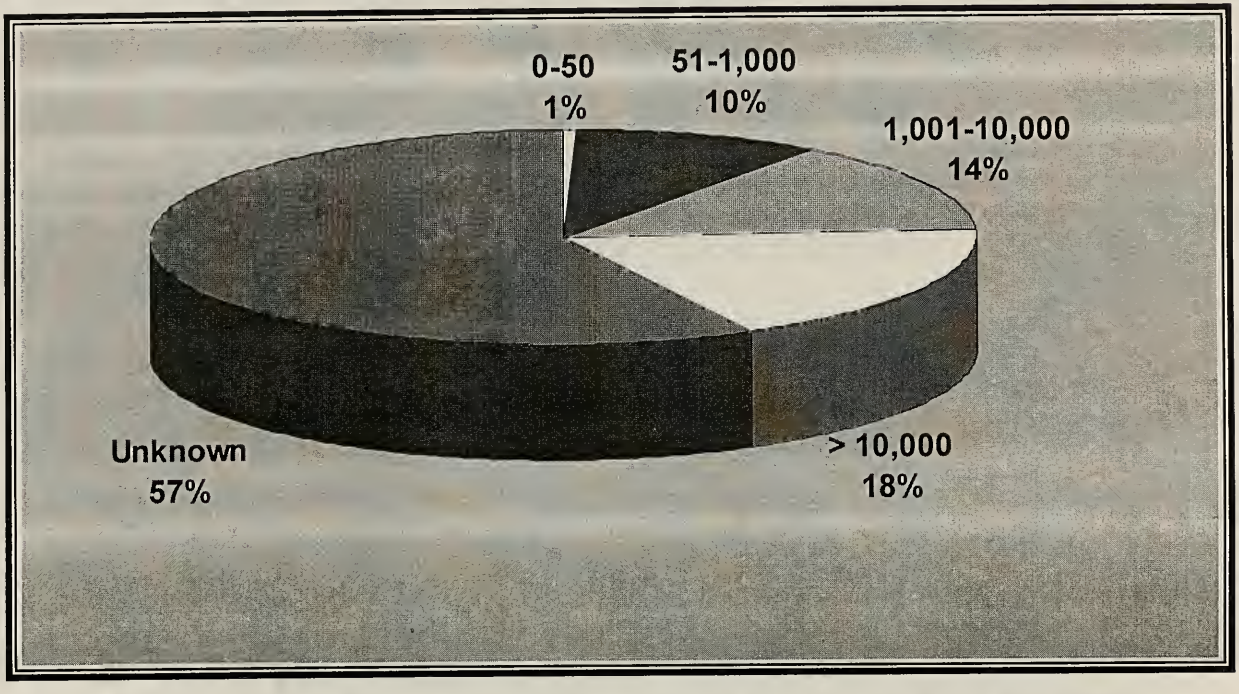
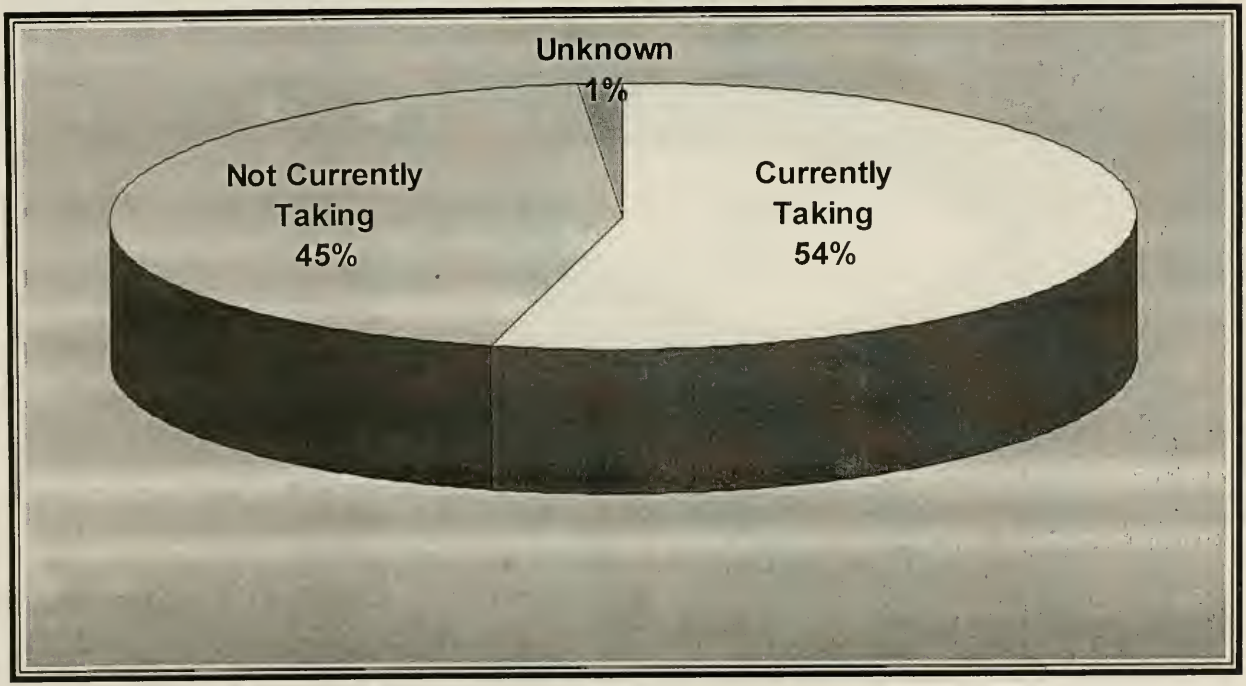
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Viral Load (n=417)



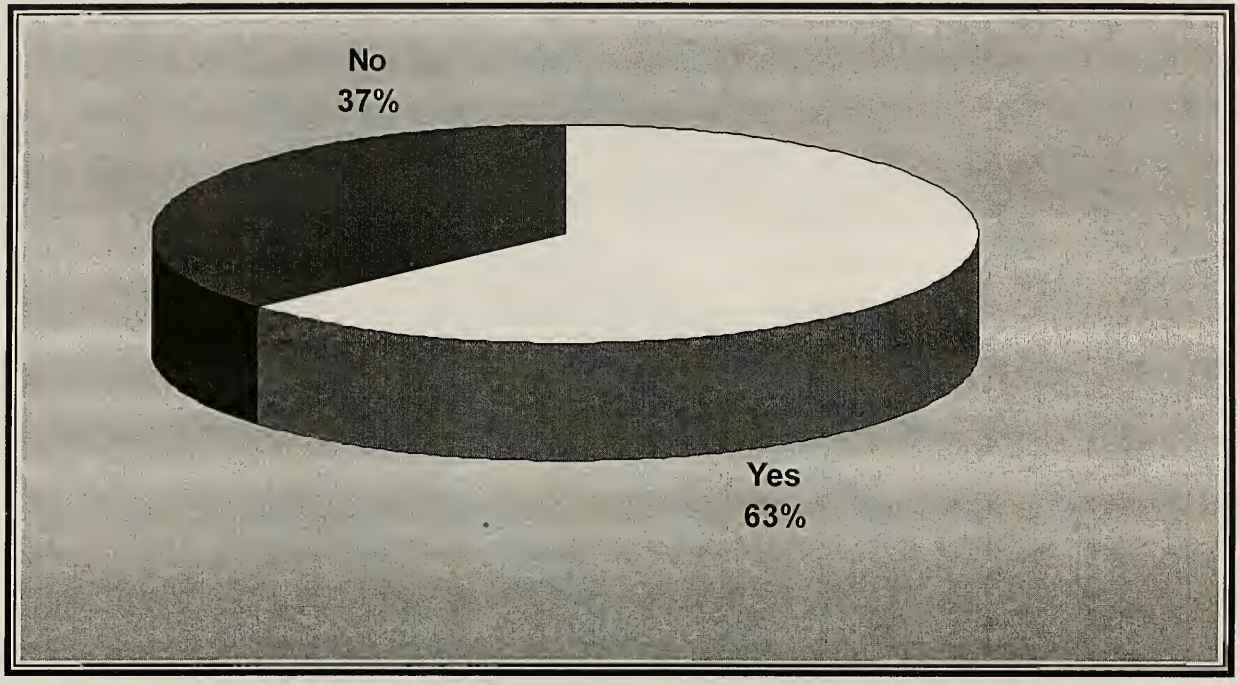
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Use of HIV/AIDS Medications (n=968)



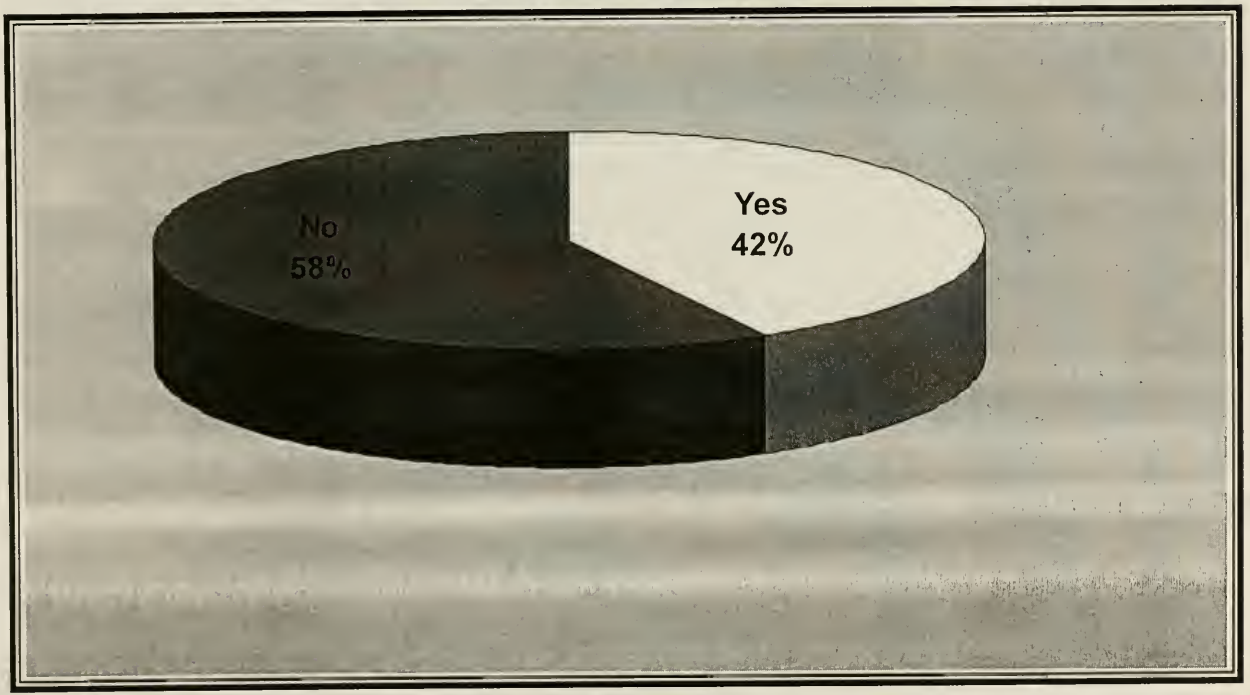
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Use of HIV/AIDS Medications - AIDS Diagnosis (n=581)



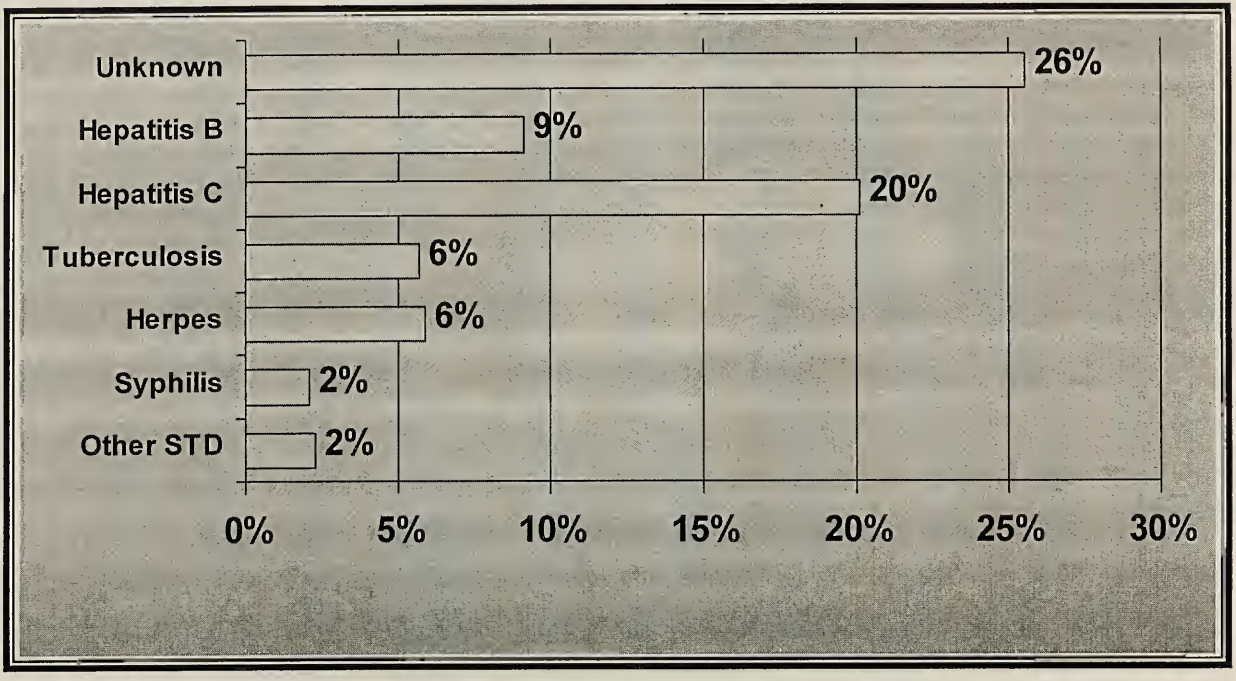
A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Have ever taken medications (n=389)



A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Other Health Problems (n=968)



Harder+Company Community Research

SAN MATEO COUNTY AIDS PROGRAM

REPORT

CLIENT SATISFACTION SURVEY
April 1999

Prepared by

Mary Jane Wood
Associate Director
San Mateo County AIDS Program

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INTRODUCTION

The staff of the AIDS Program is committed "to improve and assure the quality of service provided by its medical, social and nursing services". One method of obtaining client feedback to assess the clients' perceived quality of care is to administer a client satisfaction survey. This is now done routinely every year in April.

The following is a report of survey results from the April 1999 administration. A copy of the survey is attached (Appendix A). Ninety-eight (98) responses were received from the 293 clients that were seen in the Clinic for a response rate of 34%. This return rate continues a trend of very good return rates on all of the client satisfaction surveys that have been administered to date.

A presentation and discussion of the findings, including limitations of the survey, follow.

LIMITATIONS

Several limitations must be considered when reviewing the results of the survey. First, only those adult clients actually seen in the month of April were given an opportunity to respond to the survey. Therefore, although the population surveyed appears representative of the entire adult population of clients served by the AIDS Program, one still must look at the results with caution (See Tables 1, 2, and 3).

Second, although 34% of those offered the opportunity to complete the survey actually did so, which is an very high return rate for a survey of this type, and the respondents' demographics were fairly representative of the client population (See Tables 1, 2, and 3), there were still some minor differences, particularly in the area of ethnicity where proportionately many more latino/a clients completed the survey than were seen during the month or over the year.

Third, the survey is a relatively gross instrument that did not obtain much in-depth information about the respondent or about, for example, the identity of the various providers for that particular individual. Therefore, although the survey does provide general information about the respondent's level of satisfaction, it does not provide information about specific providers and the respondent's satisfaction with those providers.

FINDINGS

Tables 1, 2 and 3 contain a summary of the respondent demographics. Tables 4, 5 and 6 present the averages (4) and number of responses per question (5) and percentages (6). Tables 7 and 8 present the a comparison of means for the surveys conducted for the periods 10/92 thru 4/99 (7) and differences in means scores for the surveys conducted between 4/94 and 4/99 (8).

The second question in the survey concerning quality of services is subdivided into 15 separate categories of service. Each question has a possible range of 4 (Excellent, Very Satisfied or Very Well) to 1 (Poor, Very Unsatisfied or Poorly). Also, for the subcategories of question 2, the

respondent could indicate that he/she has not used that particular service rather than rating the service.

As demonstrated in Table 4, every question resulted in a mean score of greater than 3.46, with the lowest score being for question 5 concerning "condition of the facilities" (Mean=3.46) and the highest score was for question 1 concerning how the respondent perceived his/her treatment by the program staff (Mean=3.85). The pattern of responses is the same as in past surveys.

In the survey conducted in April 1998, it was found that the mean scores had decreased on responses to all of the questions, including the grand mean on question 2, compared to April 1996 results. However, in this current survey, the mean scores increased over those obtained in the previous survey for questions 1 - How well were you treated by program staff?, 2 - How would you rate the quality of services provided?, 3 -How would you rate staff knowledge?, and 6 - What is you overall level of satisfaction with services provided?. Questions 4 and 5 concerning organization of staff in the clinic and condition of facilities showed minimal negative differences in mean scores (-.01 for both). (See Tables 7 and 8)

With regard to quality of service (question 2) the grand mean was 3.72 and the range of subcategory means was 3.56 to 3.93. The highest scores were given for reception staff (3.93), medical doctors (3.87), NPs/PAs (3.84), and nursing (3.83). All of these means were higher than those of the previous year. The lowest mean score was 3.56 for benefits counseling. However, with the exception of responses concerning the AIDS Drug Assistance Program (ADAP), all the mean scores regarding services listed were higher than those of the previous year. (See Tables 7 and 8). The decrease in the ADAP mean score was -.05; however, the overall mean score for ADAP was 3.70. Overall, the decrease or increase in means scores in various categories was not significant with the possible exception of clinical trials and mental health counseling with increases of .22 and .27 respectively.

On average, respondents who answered a given question and/or who had experience of a service, continued to feel that: (1) they were treated very well by the program staff; (2) they received good to excellent services in most service areas; (3) staff knowledge was good to excellent; (4) staff organization was good to excellent; (5) condition of facilities was good to excellent; and, (6) they were very satisfied with the services they received. Ninety-nine percent (99%) of the clients who responded to the question were either very satisfied or satisfied with the services they receive, with 71% being very satisfied.

Respondents were also asked what they liked least about the program, what they liked best, and to give suggestions (See Appendix B). Of the 55 statements about what they liked least, 26 were truly negative statements. Twenty-nine (29) of the comments were statements like "None", "Nothing", "No Complaints", etc. Of the 26 negative comments, 6 were general comments about concerns over which the program has no control (e.g., "change", "Pharmacy needs lots of work getting drugs out", "the hospital's accounting department", etc.). The remaining 20 concerns

were related to either services in the clinic or the facility. For example, "...some of the reading material should be put in another place because of its contents are not for everybody, "small reception room is cramped. Drop-in center is small and industrial refrigerator is too loud/noisy", "sometimes the waiting", etc.

The majority of the complaints over which the program has some control concerned the facility (11 complaints) and client waiting time (5 complaints). The facility complaints were exclusively related to the size of the new facility. Client waiting time concerns were about evenly split between waiting to see a physician for an appointment and waiting time between appointments.

Of the 74 statements about what they liked most about the program, the majority referred to the quality, caring and compassion of the staff. For example, "The staff is extremely helpful and understanding, They seem to go out of their way to explain and make be feel comfortable"; "The overall generosity, knowledge and friendliness of all the staff here. They always make me feel welcome. Very much so!!"; "Everyone goes over and beyond the call of duty to help you"; "That no one was afraid (of us), each person is treated like they're special, and everyone is very helpful"; etc.

Twenty-five (25) suggestions or comments were made. The majority of these were comments such as "Keep up the good work". Specific suggestions included: "Better air conditioning in waiting room"; " Provide literature/pamphlets with health information in Spanish - such as, how to prevent venereal diseases and other types of disease"; "The chairs in the waiting room are dirty - I'd rather stand. Knock out another wall. It's too small (smile)"; "Just speed up a hair"; "Perhaps the individuals who answer the phone could identify themselves when talking to the patient"; etc. In addition to further comments about the lack of space, a couple of clients did comment on the reading material in the waiting room, particularly that only gay oriented material seemed to be available and some of the material was not appropriate reading material for everyone.

DISCUSSION

The clients who completed the survey are in general very satisfied with the services they receive from the AIDS Program. There continues to be a pattern of discontent with wait times; however, several studies conducted by the program have demonstrated that wait times are no longer than those of other clinics generally, and are considerably less than the wait times in the hospital's outpatient clinics.

With the move of the clinic to the new facility, there seems to be a significant amount of dissatisfaction with the new facility, particularly it's size. Eleven (11) comments about what they liked least about the clinic concerned the small size of the clinic, particularly the waiting room and drop-in center. Eleven (11) comments about any one issue is the most that have ever been made by clients since the administration of these surveys began in 1992. It is questionable, however, as to how much control we have over the size of the clinic and/or the waiting room and drop-in center.

Overall, the results of this survey are very encouraging. The overall and specific satisfaction ratings continue to be positive. When one looks at the means, even the ones that have declined from last year, it is apparent that over a several year period of time the scores are basically stable and represent a high level overall satisfaction on the part of our clients.

TABLE 1

Comparison on Gender for Total Clients Served
Since 7/1/98, Clients Served in April, 1999, and
Survey Respondents

GENDER	TOTAL CLIENTS SERVED	CLIENTS SERVED IN APRIL	SURVEY RESPONDENTS
Male	73%	73%	64%
Female	26%	26%	36%
Other or Unknown	1%	1%	0%
TOTAL	100% (N=549)	100% (N=293)	100% (N=98)

TABLE 2

Comparison on Ethnicity for Total Clients Served Since 7/1/98, Clients Served in April, 1999, and Survey Respondents

ETHNICITY	TOTAL CLIENTS SERVED	CLIENTS SERVED IN APRIL	SURVEY RESPONDENT
Caucasian	42%	43%	37%
African American	34%	30%	26%
Latino/a	18%	21%	28%
Asian/Pac.Isl.	2%	2%	2%
American Indian/ Alas.Nat.	0%	0%	1%
Other/Unknown	4%	4%	7%
TOTAL	100% (N=549)	100% (N=293)	100% (N=98)

TABLE 3

Comparison on Age for Total Clients Served
Since 7/1/98, Clients Served in April, 1999, and
Survey Respondents

AGE	TOTAL CLIENTS SERVED	CLIENTS SERVED IN APRIL	SURVEY RESPONDENTS
19 or less	2%	2%	1%
20-24 Yrs.	1%	1%	1%
25-29 Yrs.	5%	5%	1%
30-39 Yrs.	37%	38%	38%
40-49 Yrs.	38%	35%	38%
50-59 Yrs.	12%	13%	13%
>=60 Yrs.	5%	6%	6%
Unknown	0%	0%	5%
TOTAL	100% (N=549)	100% (N=293)	100% (N=98)

Table 4

San Mateo County AIDS Program
Client Satisfaction Survey Results
Survey Administered April 1999

Averages and Sample Size

1) How well were you treated by program staff?

Avg. = 3.85 N = 97 No Response or Service Not used= 1

2) How would you rate the quality of services provided?

Reception Staff	Avg. = 3.93 N = 98	No Response or Service Not used= 0
Phone Courtesy	Avg. = 3.82 N = 94	No Response or Service Not used= 4
Medical Doctors	Avg. = 3.87 N = 95	No Response or Service Not used= 3
Nurse Practitioner/ Physician's Assistant	Avg. = 3.84 N = 96	No Response or Service Not used= 2
Nursing	Avg. = 3.83 N = 94	No Response or Service Not used= 4
Clinical Trials	Avg. = 3.67 N = 63	No Response or Service Not used= 35
Substance Abuse Counseling	Avg. = 3.62 N = 55	No Response or Service Not used= 43
Nutrition Counseling	Avg. = 3.66 N = 58	No Response or Service Not used= 40
Social Work	Avg. = 3.64 N = 80	No Response or Service Not used= 18
Mental Health Counseling	Avg. = 3.63 N = 65	No Response or Service Not used= 33
Benefits Counseling	Avg. = 3.56 N = 64	No Response or Service Not used= 34
AIDS Drug Assistance Program	Avg. = 3.70 N = 70	No Response or Service Not used= 28
Health Education	Avg. = 3.69 N = 62	No Response or Service Not used= 36
Drop-In Center	Avg. = 3.70 N = 63	No Response or Service Not used= 35
Support Groups	Avg. = 3.68 N = 47	No Response or Service Not used= 51

3) How would you rate staff knowledge?

Avg. = 3.73 N = 96 No Response or Service Not used= 2

4) How would you rate organization of staff in the clinic?

Avg. = 3.59 N = 96 No Response or Service Not used= 2

5) How would you rate condition of facilities (exam room, etc.) at the clinic?

Avg. = 3.46 N = 98 No Response or Service Not used= 0

6) What is your overall level of satisfaction with services provided:

Avg. = 3.69 N = 98 No Response or Service Not used= 0

Table 5

San Mateo County AIDS Program
Client Satisfaction Survey Results
Survey Administered April 1999

Responses Per Category
(N= 98)

1) How well were you treated by program staff?

Very Well = 82 Well = 15 O.K. = 0 Poorly = 0 No Response = 1

2) How would you rate the quality of services provided?

SERVICE	Excellent	Good	Average	Poor	Not Used	No Response
	N	N	N	N	N	N
Reception Staff	92	5	1	0	0	0
Phone Courtesy	80	12	1	1	3	1
Medical Doctors	83	12	0	0	2	1
Nurse Practitioner/Physician's Asst.	83	11	2	0	2	0
Nursing	80	12	2	0	4	0
Clinical Trials	46	13	4	0	27	8
Substance Abuse Counseling	38	14	2	1	37	6
Nutrition Counseling	41	14	3	0	33	7
Social Work	58	15	7	0	14	4
Mental Health Counseling	47	13	4	1	26	7
Benefits Counseling	41	18	5	0	27	7
AIDS Drug Assistance Program	51	17	2	0	25	3
Health Education	46	13	3	0	27	9
Drop-In-Center	49	10	3	1	26	9
Support Groups	34	11	2	0	45	6

3) How would you rate staff knowledge?

Excellent = 73 Good = 20 Average = 3 Poor = 0 No Response = 2

4) How would you rate organization of staff in the clinic?

Excellent = 62 Good = 29 Average = 5 Poor = 0 No Response = 2

5) How would you rate condition of facilities (exam room, etc.) at the clinic?

Excellent = 60 Good = 26 Average = 9 Poor = 3 No Response = 0

6) What is your overall level of satisfaction with services provided:

Very Satisfied = 69 Satisfied = 28 Somewhat Unsatisfied = 1 Very Unsat.= 0 No Response = 0

GENDER: Male = 63 Female = 34 No Response = 0

AGE: 19 or Less = 0 30 - 39 = 37 60 or More = 6
20 - 24 = 1 40 - 49 = 35 No Res. = 5
25 - 29 = 1 50 - 59 = 13

ETHNICITY: White = 36 Asian/Pac.Isl. = 2 No Response = 2
African/American = 25 Amer.Ind./Nat.Am. = 1
Latino/a = 27 Other = 5

Table 6

Quality of Services Provided
in Percents
April 1999 Survey

1) How well were you treated by program staff?

Very Well	Well	OK	Poorly
84.54%	15.46%	0.00%	0.00%

2) How would you rate the quality of services provided?

	Excellent	Good	Average	Poor
Reception Staff	93.88%	5.10%	1.02%	0.00%
Phone Courtesy	85.11%	12.77%	1.06%	1.06%
Medical Doctors	87.37%	12.63%	0.00%	0.00%
Nurse Practitioner/Physician's Asst.	86.46%	11.46%	2.08%	0.00%
Nursing	85.11%	12.77%	2.13%	0.00%
Clinical Trials	73.02%	20.63%	6.35%	0.00%
Substance Abuse Counseling	69.09%	25.45%	3.64%	1.82%
Nutrition Counseling	70.69%	24.14%	5.17%	0.00%
Social Work	72.50%	18.75%	8.75%	0.00%
Mental Health Counseling	72.31%	20.00%	6.15%	1.54%
Benefits Counseling	64.06%	28.13%	7.81%	0.00%
AIDS Drug Assistance Program	72.86%	24.29%	2.86%	0.00%
Health Education	74.19%	20.97%	4.84%	0.00%
Drop-in-Center	77.78%	15.87%	4.76%	1.59%
Support Groups	72.34%	23.40%	4.26%	0.00%

3) How would you rate staff knowledge?

Excellent	Good	Average	Poor
76.04%	20.83%	3.13%	0.00%

4) How would you rate organization of staff in the clinic?

Excellent	Good	Average	Poor
64.58%	30.21%	5.21%	0.00%

5) How would you rate condition of facilities in clinic?

Excellent	Good	Average	Poor
61.22%	26.53%	9.18%	3.06%

6) What is your overall level of satisfaction with services provided?

Very Sat.	Satisfied	Unsatisfied	Very Unsat.
70.41%	28.57%	1.02%	0.00%

Table 7

Comparison of Survey Results for Period 10/92 through 4/99
Comparison of Mean Scores

	10/92	4/93	10/93	4/94	4/95	4/96	4/97	4/98	4/99
1) How well were you treated by program staff?	3.86	3.86	3.93	3.90	3.81	3.78	3.81	3.76	3.85
2) How would you rate the quality of services provided?									
Reception Staff	3.60	3.82	3.80	3.89	3.88	3.81	3.82	3.78	3.93
Phone Courtesy	3.54	3.86	3.64	3.81	3.77	3.72	3.65	3.71	3.82
Medical Doctors	3.76	3.91	3.79	3.71	3.76	3.80	3.76	3.76	3.87
Nurse Practitioners/PAs	3.73	3.86	3.79	3.71	3.75	3.76	3.79	3.76	3.84
Nursing	3.66	3.84	3.75	3.68	3.79	3.74	3.79	3.80	3.83
Clinical Trials	3.46	3.65	3.48	3.70	3.51	3.40	3.70	3.45	3.67
Substance Abuse Couns.	3.28	3.77	3.66	3.67	3.41	2.90	3.68	3.54	3.62
Nutrition Counseling	3.42	3.66	3.56	3.47	3.38	3.33	3.55	3.39	3.66
Social Work	3.45	3.73	3.65	3.65	3.62	3.40	3.58	3.62	3.64
Mental Health Couns.	3.21	3.64	3.63	3.56	3.63	3.44	3.67	3.49	3.63
Benefits Counseling.	NA	NA	NA	NA	NA	3.41	3.53	3.42	3.56
AIDS Drug Assis. Prog.	NA	NA	NA	NA	NA	3.64	3.68	3.75	3.70
Health Education	3.33	3.59	3.64	3.65	3.51	3.44	3.68	3.62	3.69
Drop-In-Center	3.37	3.83	3.62	3.75	3.75	3.51	3.75	3.68	3.70
Support Groups	3.41	3.79	3.46	3.75	3.71	3.62	3.62	3.49	3.68
3) How would you rate staff knowledge?	3.64	3.75	3.71	3.69	3.68	3.61	3.64	3.70	3.74
4) How would you rate organization of staff in the clinic?	3.35	3.73	3.59	3.62	3.59	3.44	3.50	3.60	3.59
5) How would you rate condition of facilities?	3.76	3.79	3.70	3.69	3.62	3.51	3.46	3.47	3.46
6) What is your overall level of satisfaction with services provided?	3.62	3.79	3.65	3.71	3.66	3.62	3.55	3.67	3.69

Table 8

Mean Difference Scores

	Mean Diff. 95-96	Mean Diff. 96-97	Mean Diff. 97-98	Mean Diff. 98- 99
) How well were you treated by program staff?	-0.03	0.03	-0.05	0.09
) How would you rate the quality of services provided?				
Reception Staff	-0.07	0.01	-0.04	0.15
Phone Courtesy	-0.05	-0.07	0.06	0.11
Medical Doctors	0.04	-0.04	0.00	0.11
Nurse Practitioners/PAs	0.01	0.03	-0.03	0.08
Nursing	-0.05	0.05	0.01	0.03
Clinical Trials	-0.11	0.30	-0.25	0.22
Substance Abuse Couns.	-0.51	0.78	-0.14	0.08
Nutrition Counseling	-0.05	0.22	-0.16	0.27
Social Work	-0.22	0.18	0.04	0.02
Mental Health Couns.	-0.19	0.23	-0.18	0.14
Benefits Counseling.	NA	0.12	-0.11	0.14
AIDS Drug Assis. Prog.	NA	0.04	0.07	-0.05
Health Education	-0.06	0.23	-0.06	0.07
Drop-In-Center	-0.19	0.19	-0.07	0.02
Support Groups	-0.23	0.14	-0.13	0.19
) How would you rate staff knowledge?	-0.07	0.03	0.06	0.04
) How would you rate organization of staff in the clinic?	-0.15	0.06	0.10	-0.01
) How would you rate condition of facilities?	-0.11	-0.05	0.01	-0.01
) What is your overall level of satisfaction with services provided?	-0.04	-0.07	0.12	0.02

APPENDIX A

SAN MATEO COUNTY AIDS PROGRAM
CLIENT SATISFACTION SURVEY

Directions: Choose your answer by circling a response, marking in a box or filling in the blank.

1) How well were you treated by the program staff?

Very Well Well OK Poorly

2) How would you rate the quality of services provided (please check answers)?

Service	Excellent	Good	Average	Poor	Not Used
Reception Staff					
Phone Courtesy					
Medical Doctors					
Nurse Practitioner/ Physician's Assistant					
Nursing					
Clinical Trials					
Substance Abuse Counseling					
Nutrition Counseling					
Social Work					
Mental Health Counseling					
Benefits Counseling					
AIDS Drug Assistance Program					
Health Education					
Drop-In Center					
Support Groups					

3) How would you rate staff knowledge?

Excellent Good Average Poor

4) How would you rate organization of staff in the clinic?

Excellent Good Average Poor

5) How would you rate condition of facilities (exam room, waiting room, Drop-In Center, etc...) at the clinic?

Excellent Good Average Poor

6) What is your overall level of satisfaction with services provided:

Very Satisfied Satisfied Somewhat Unsatisfied Very Unsatisfied

7) What do you like most about our program or about your experience here?

_____

_____

_____

8) What do you like least about our program or about your experience here?

_____

_____

_____

9) Any comments or suggestions?

_____

_____

_____

Please respond to the following questions about yourself:

1. Gender: _____ Male _____ Female
2. Age: _____
3. Ethnicity: _____ Caucasian _____ African-American _____ Latino/a _____ Asian/Pacific Islander _____ American Indian, Aleutian, Native Alaskan or Eskimo _____ Other

Please place the completed survey in the box provided in the main waiting room.
Thanks for participating!

San Mateo County AIDS Program
Client Satisfaction Survey Results
Survey Administered April 1999

Respondent Statements of Most Liked, Least Liked and General Comments about Clinic

by questionnaire number

1.	Like Most:	The fresh water, the couch
	Like Least:	There is no databse that we can work on.
	Comments:	Have an internet service hook-up.
2.	Like Most:	Everything and everybody.
	Like Least:	Nothing.
	Comments:	
3.	Like Most:	Everything - I would hate to leave you!
	Like Least:	Hard to get appointment sometimes.
	Comments:	
4.	Like Most:	How the staff is concerned about how you feel and how they explain any questions you give out to them. When the staff is overwhelmed they are still working hard to help you.
	Like Least:	
	Comments:	Lunch served here in the clinic is something extra special that I really like.
5.	Like Most:	Staff is very friendly and honest.
	Like Least:	
	Comments:	
6.	Like Most:	The people and doctor.
	Like Least:	Nothing
	Comments:	No
7.	Like Most:	
	Like Least:	
	Comments:	It would be nice if the receptionist would identify herself when answering the phone.
8.	Like Most:	Overall treatment is excellent.
	Like Least:	
	Comments:	
9.	Like Most:	The service given.
	Like Least:	Nothing much. But some of the reading material should be put in another place because of its contents are not for every body.
	Comments:	No.
10.	Like Most:	Excellent
	Like Least:	Excellent
	Comments:	Excellent

11.	Like Most:	Staff works well with me on all my needs.
	Like Least:	Nothing.
	Comments:	Keep on satisfying the clients.
12.	Like Most:	The people at the clinic are very good to me.
	Like Least:	
	Comments:	Everything is going well.
13.	Like Most:	Very nice attitudes, feel welcome.
	Like Least:	Waiting too long while seeing doctor.
	Comments:	Just speed up a hair.
14.	Like Most:	Mark Traves and the staff that support all of us.
	Like Least:	Pharmacy needs lots of work getting drugs out!
	Comments:	Pharmacy service is very poor, lots of work needed there.
15.	Like Most:	Courtesy of staff (reception, nurses, physician's assistant). (I don't really see Dr. Israelski; but the few times I have, he is also very courteous).
	Like Least:	Small reception room is cramped. Drop-in center is small and industrial refrigerator is too loud/noisy!
	Comments:	I miss the old portable building. I liked the lay-out there more than new facilities. This is why I gave #5 above a "good" rating and not more; even though facilities are exceptionally clean, neat, orderly inside exam rooms.
16.	Like Most:	It's not impersonal. I like that treatments here are very progressive. My PA-C takes an aggressive route in my treatment with use of certain drugs that have made me feel better.
	Like Least:	I like everything.
	Comments:	
17.	Like Most:	Convenient.
	Like Least:	Nothing.
	Comments:	Would like to see other magazines in waiting room other than homosexual magazines. Thank you.
18.	Like Most:	Don't like it but the staff is very good.
	Like Least:	
	Comments:	
19.	Like Most:	Quality of service with excellent bedside manner.
	Like Least:	Not applicable.
	Comments:	Improvements could be made in space provided for clinic and reception area with access to outside patio or area for waiting.
20.	Like Most:	Very thorough, very accomodating, very friendly.
	Like Least:	
	Comments:	
21.	Like Most:	Respect.
	Like Least:	
	Comments:	

22.	Like Most:	Friendly staff.
	Like Least:	Small waiting area.
	Comments:	None.
23.	Like Most:	The programs that this clinic provides are very effective in restoring the lives of PWA/HIV. My experience with this clinic and the programs has been fulfilling and rewarding. You are the best!!
	Like Least:	There's nothing I like least and never had a bad experience yet! So keep up the good work that you all do so well.
	Comments:	The chairs in the waiting are dirty - I'd rather stand. Knock out another wall, it's too small (smile).
24.	Like Most:	Consistency
	Like Least:	Benefits follow up and long term continuation.
	Comments:	Thanks guys.
25.	Like Most:	staff/location/services available
	Like Least:	Sometimes having to wait more than 30 min. for appointment.
	Comments:	None, very satisfied.
26.	Like Most:	
	Like Least:	No emergency services
	Comments:	
27.	Like Most:	The staff is very friendly.
	Like Least:	The waiting room is too small.
	Comments:	
29.	Like Most:	The people do care.
	Like Least:	Sometimes the waiting.
	Comments:	Keep up the good work.
30.	Like Most:	Medical staff, knowledge, programs, level of treatment, etc.
	Like Least:	Lack of size in drop in center and clinic waiting area is like a coffin, too small, walls closing in. Can't breathe, no space, claustrophic waiting area.
	Comments:	See above.
31.	Like Most:	Familiarity - professionalism.
	Like Least:	Change.
	Comments:	
32.	Like Most:	Them being very knowledgeable about certain situations.
	Like Least:	Things about the billing of bills which should go to my providers as bills opposed coming to me.
	Comments:	When medication is on going why is it that we as clients have to wait for approval to get medication that we need daily, weekly or whatever.
33.	Like Most:	Everything is cool.
	Like Least:	
	Comments:	

34.	Like Most:	All services at one location; not having to go to a general clinic and be exposed to colds, flu, etc., that challenge immune systems.
	Like Least:	smaller space.
	Comments:	Provide basic vitamins/nutritional supplements.
35.	Like Most:	That no one was afraid, each person is treated like they're special, and everyone is very helpful.
	Like Least:	I haven't run into anything yet.
	Comments:	Thank you.
36.	Like Most:	I am here.
	Like Least:	
	Comments:	
38.	Like Most:	Feel comfortable and at ease here.
	Like Least:	Small area in lobby and lunch area.
	Comments:	
39.	Like Most:	Caring, knowlegeable staff - all the services available.
	Like Least:	
	Comments:	
40.	Like Most:	Everybody on staff make me feel very comfortable and easy. Seems that they have excellent knowlege of counseling and other information about HIV and most current information. Only thing I can say is Thanks and keep up the good work.
	Like Least:	None
	Comments:	None
42.	Like Most:	My doctor.
	Like Least:	Can't see my doctor when I need to.
	Comments:	Have it so I can see any doctor, Mon-Fri.
43.	Like Most:	I am very pleased with the program and their assistance.
	Like Least:	Nothing at this time.
	Comments:	I am very pleased with the help and assistance in the clinic.
46.	Like Most:	Familiarity of the staff with the clients. The staff has been most helpful.
	Like Least:	Would like more attention to mental disorders
	Comments:	
47.	Like Most:	The camraderie (tr)
	Like Least:	
	Comments:	
48.	Like Most:	The attention (tr)
	Like Least:	
	Comments:	
49.	Like Most:	The good attention.
	Like Least:	
	Comments:	Good

50.	Like Most:	I like all personnel.
	Like Least:	
	Comments:	
51.	Like Most:	The attention received in general, the quality of teaching regarding health. Experiences: Independently of the good treatment of the doctors, nurses and receiptionists, I count on all of them as friends since they always make us feel comfortable. (tr)
	Like Least:	No comments (tr)
	Comments:	Provide literature/pamphlets with health information in Spanish - such as: how to prevent venereal diseases and other types of diseases. (tr)
52.	Like Most:	The attention and dedication toward the patient. (tr)
	Like Least:	
	Comments:	
54.	Like Most:	People.
	Like Least:	Nothing
	Comments:	Longer hours of drop-in center.
55.	Like Most:	No comment (good job)
	Like Least:	No comment
	Comments:	None
56.	Like Most:	None
	Like Least:	None
	Comments:	No
57.	Like Most:	Everyone goes over and beyond the call of duty to help you.
	Like Least:	
	Comments:	
60.	Like Most:	See same doctor - staff excellent.
	Like Least:	No complaints.
	Comments:	Doing a great job.
61.	Like Most:	The people and the food.
	Like Least:	The space size.
	Comments:	
62.	Like Most:	
	Like Least:	No comments.
	Comments:	
63.	Like Most:	I like the people that work here.
	Like Least:	Waiting at the pharmacy.
	Comments:	
65.	Like Most:	Staff is very kind and courteous towards clients.
	Like Least:	
	Comments:	

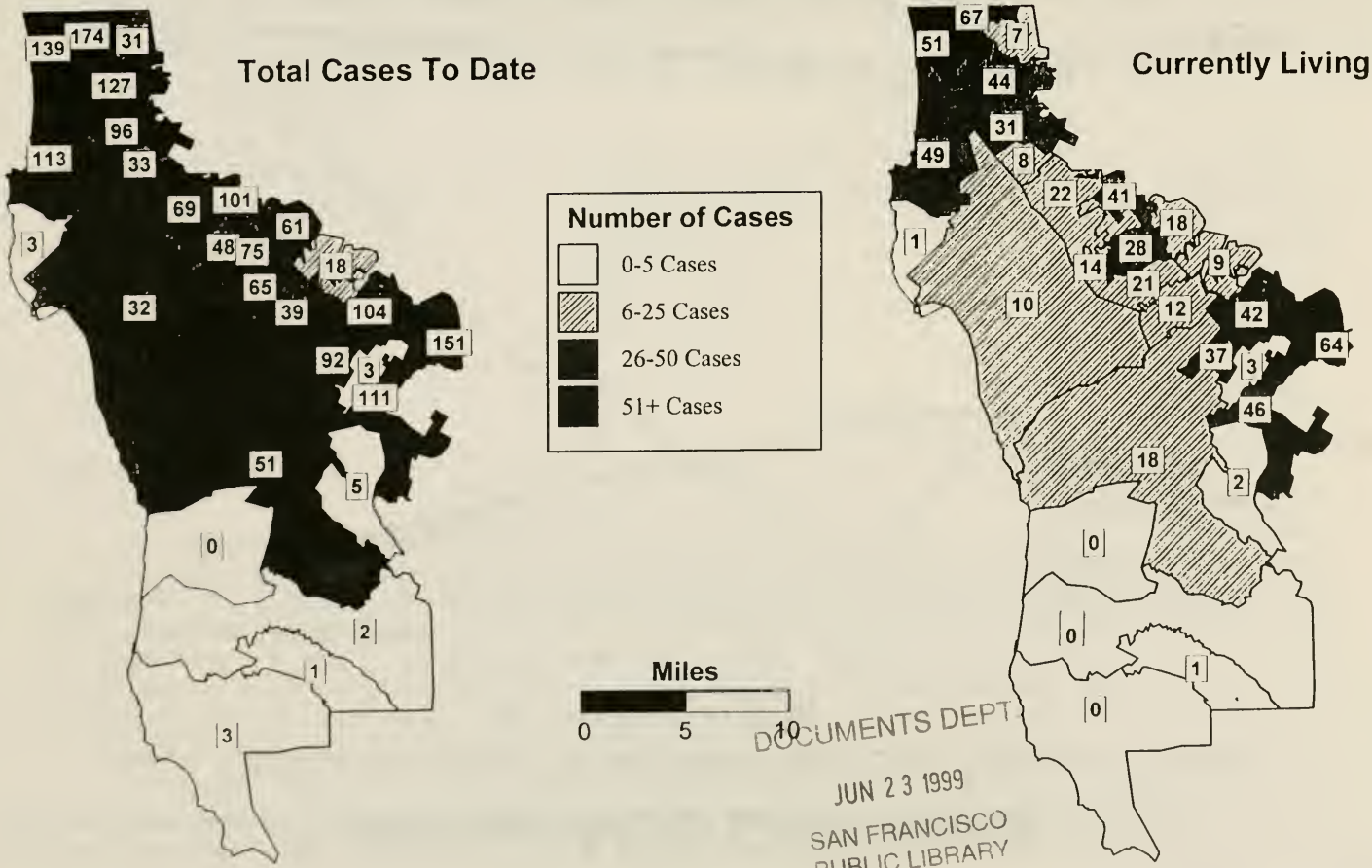
66.	Like Most:	Staff, especially trmt(?) staff
	Like Least:	space and waiting for my doctor for more than 1 hour.
	Comments:	
67.	Like Most:	Friendly atmosphere.
	Like Least:	Small waiting room, poor air flow.
	Comments:	Better air conditioning in waiting room.
68.	Like Most:	Everything.
	Like Least:	
	Comments:	
69.	Like Most:	Good.
	Like Least:	Good.
	Comments:	None.
70.	Like Most:	
	Like Least:	Experience with neuropathy.
	Comments:	
71.	Like Most:	The overall generosity, knowledge and friendliness of all the staff here. They always make me feel welcome. Very much so!!
	Like Least:	Nothing!
	Comments:	Just please keep up the good work.
73.	Like Most:	Very well.
	Like Least:	Very well.
	Comments:	Need reception area improvement.
75.	Like Most:	Friendly.
	Like Least:	No comment.
	Comments:	No comment.
76.	Like Most:	The doctors.
	Like Least:	
	Comments:	
77.	Like Most:	Everytime I come to the clinic the staff and volunteers hae been very helpful. I have nothing to say but very good things about this clinic. The people have made coming to the clinic most satisfying.
	Like Least:	
	Comments:	I think Dennis is wonderful!!!
78.	Like Most:	The doctors and the nurses and whole staff.
	Like Least:	
	Comments:	
80.	Like Most:	Very human approach to care and treatment.
	Like Least:	The hospital's accounting department.
	Comments:	

81.	Like Most:	Staff at clinic works with people with respect and support.
	Like Least:	I really haven't had any bad experiences.
	Comments:	I want to thank all staff for your help and support and yes the receptionists are wonderful.
82.	Like Most:	The attention.
	Like Least:	Waiting
	Comments:	
83.	Like Most:	I am well taken care of.
	Like Least:	
	Comments:	None.
84.	Like Most:	The staff is extremely helpful and understanding. They seem to go out of their way to explain and make me feel comfortable.
	Like Least:	I have not had an dissatisfying experience since coming here.
	Comments:	Perhaps the chairs in the waiting area and carpets could be cleaned or changed.
86.	Like Most:	Responsive so far.
	Like Least:	Hard to say, too soon.
	Comments:	
87.	Like Most:	Good communication with all personnel.
	Like Least:	The waiting room is very reduced.
	Comments:	
88.	Like Most:	Staff is friendly and personal.
	Like Least:	
	Comments:	
89.	Like Most:	They are polite, caring, understanding, very supportive, keep smiles.
	Like Least:	N/A
	Comments:	Just keep on doing what your doing.
92.	Like Most:	Well informed, extremely courteous and all the staff goes that extra step. It shows to the client that everyone here enjoys their job; which is not an easy one. Have been a patient 12 years now with Philip Eastman and now Grace Hassid.
	Like Least:	Can't think of anything.
	Comments:	Please contact Bay Times (S.F. Newspaper) for delivery here - no papers since Clinic moved.
93.	Like Most:	
	Like Least:	Waiting area too small.
	Comments:	
94.	Like Most:	That the staff know you by your first name.
	Like Least:	
	Comments:	Keep up the good work.

95.	Like Most:	The staff is very kind and tends to the needs of the patient in a courteous and expeditious manner.
	Like Least:	I am distressed by the hospital staff (they tend to treat everyone in an abusive manner). The Program staff always works very hard to be nice.
	Comments:	1. Saturday or evening appointments. 2. A better way of getting a doctor dunng evenings/weekends (ER is not helpful in non-emergency. 3. Better appointment schedules (usually need to wait a month for follow-up appointments).
97.	Like Most:	Niceness.
	Like Least:	
	Comments:	
98.	Like Most:	People have consideration for the clients and are canng.
	Like Least:	I have no complaints.
	Comments:	That this program last a long time to help me last a long time.

AIDS Cases (Total and Living) by Zip Code

San Mateo County - diagnosed as of Jan 1, 1999



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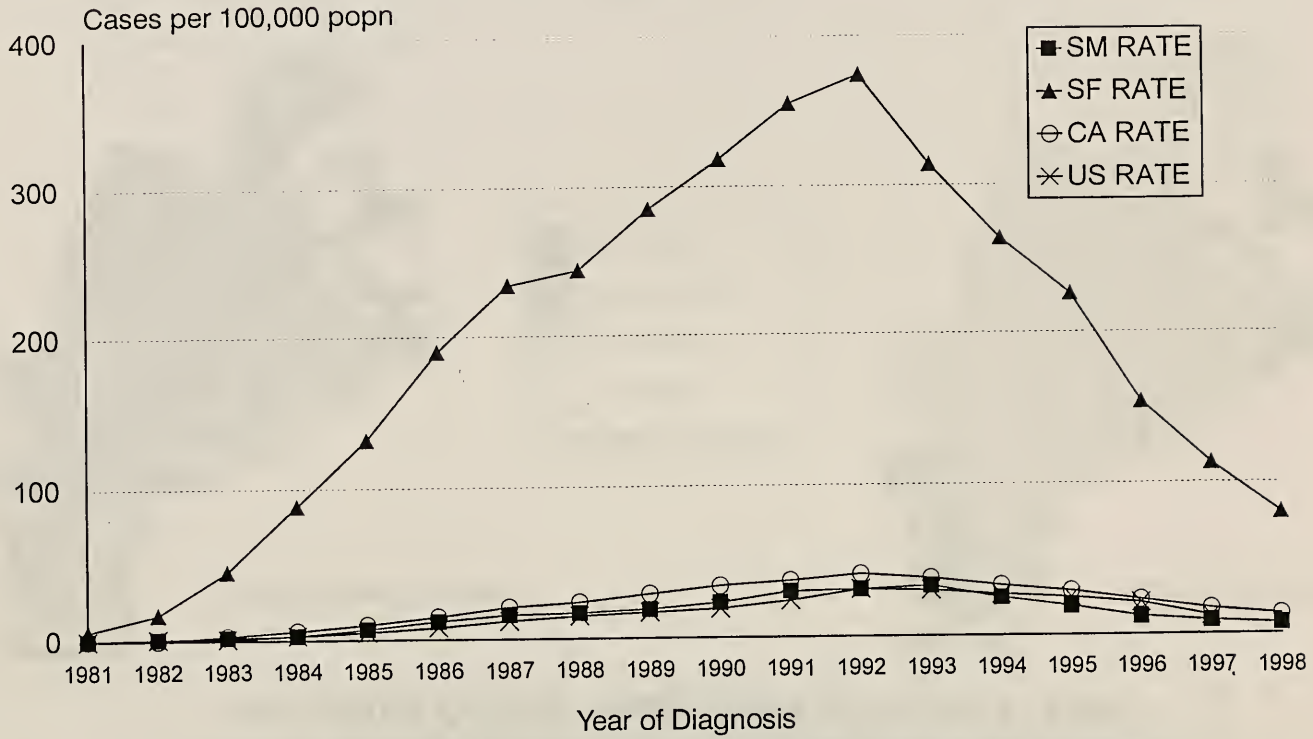
Annual AIDS Case Rates

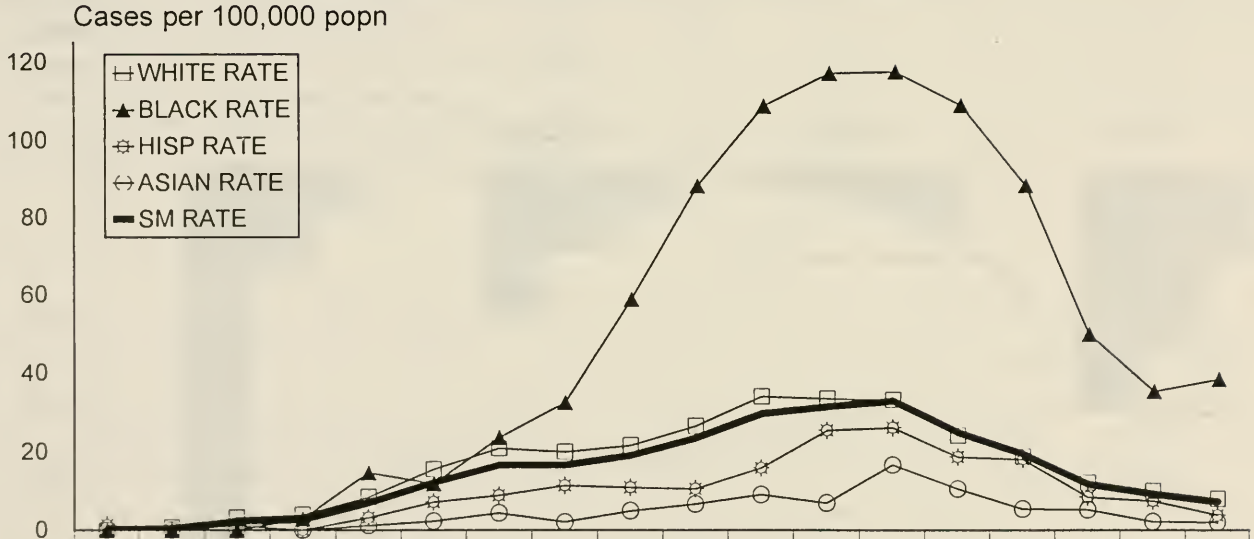
US, California, San Francisco, and San Mateo County, 1982-1998



Data: San Mateo Health Services Agency, Disease Control and Prevention Unit, HIV/AIDS Database (HARS), 5/99.
Population data from CA Dept. of Finance and US Census Bureau.

AIDS Case Rates by Race and Year of Diagnosis

San Mateo County, 1982 - 1998



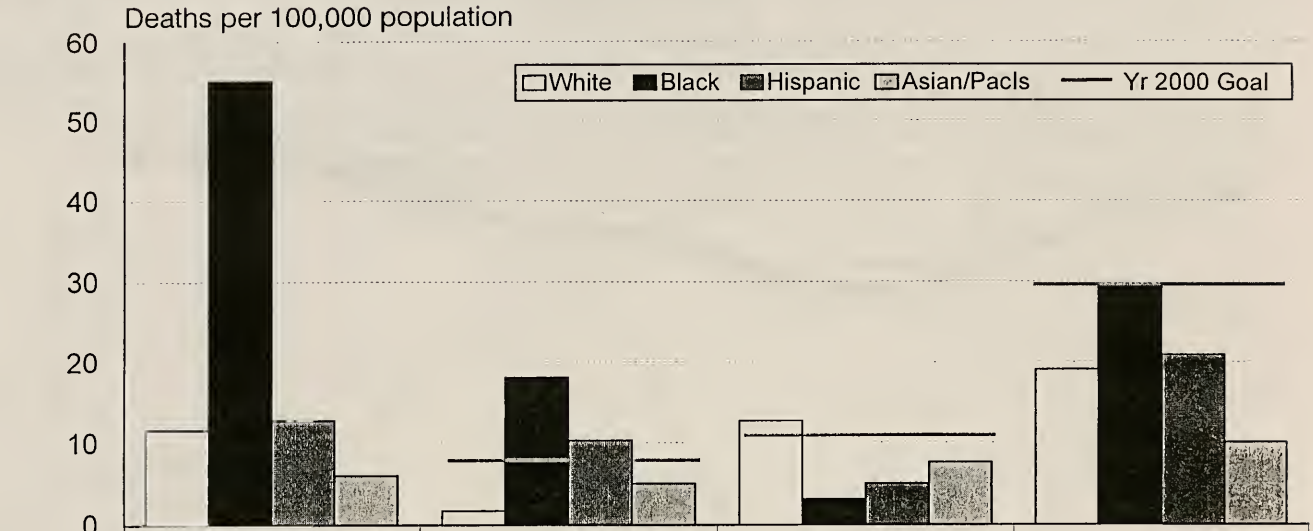
	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
WHITE RATE	0	0.7	3.2	3.9	8.4	15.5	20.9	20	21.6	26.5	34.1	33.5	33.2	24.1	18.7	12	9.9	7.9
BLACK RATE	0	0	0	2.9	14.6	11.8	23.6	32.5	58.9	88.2	108.8	117.1	117.5	109	88.4	50	35.4	38.5
HISP RATE	1.3	0	1.2	0	3.2	7.1	8.8	11.3	10.8	10.4	15.8	25.4	26.1	18.6	18	8.3	7.4	3.8
ASIAN RATE	0	0	0	0	1.2	2.3	4.4	2.1	4.9	6.6	9	6.9	16.6	10.4	5.4	5.2	2.2	2
SM RATE	0.2	0.5	2.3	2.8	7	12.1	16.6	16.6	19.1	23.5	29.7	31.5	33	24.9	19.4	11.7	9.2	7.2

Year of Diagnosis

Data: San Mateo Health Services Agency, Disease Control and Prevention Unit, HIV/AIDS Database (HARS), 5/99.
Population data from CA Dept. of Finance.

Selected Causes of Death By Race

San Mateo County, Three Year Average, 1994-1996

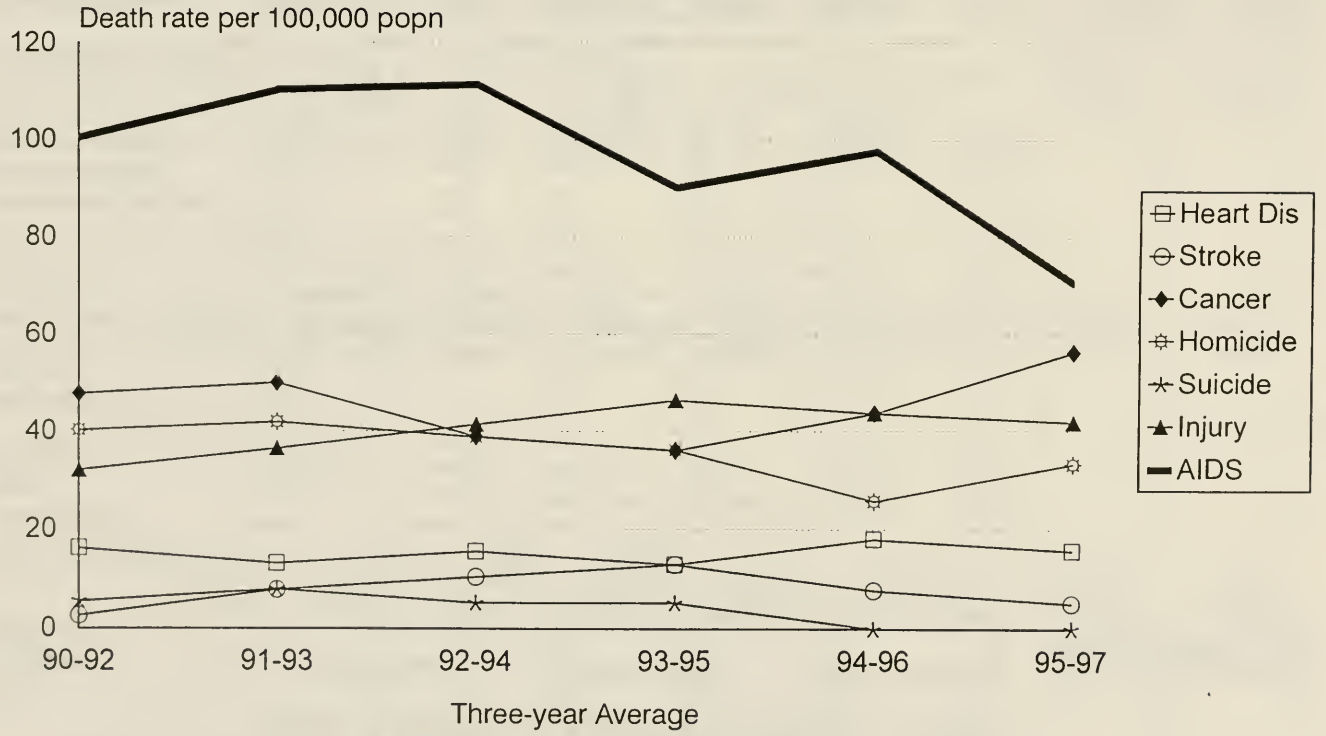


	AIDS	Homicide	Suicide	Injury
White	11.6	1.7	12.7	19.1
Black	55	18.2	3.1	29.4
Hispanic	12.8	10.3	5	20.9
Asian/PacIs	6	5	7.6	10
Total	12.4	5.3	10	18.2
Yr2000		7.2	10.5	29.3

Rates are age-adjusted and standardized to the 1940 U.S. population.
Data: San Mateo County Department of Public Health, Disease Control and Prevention Unit,
1994-1996 Death Records and CA Dept. of Finance population estimates with local adjustment.

Selected Ranked Causes of Death: Blacks 25-44 Years of Age

San Mateo County, 1990-1997



Data: San Mateo County, Department of Public Health,
Disease Control and Prevention Unit, Death Records 1990-1997.

HIV Prevalence Estimates, Subpopulations

San Mateo County, 1990 - 1997

Population Category	1994 Estimate		1996 Estimate		1997 Revision		CA DHS Model	
	Range	Mean % Pe	Range	Mean % Pe	Range	Mean % Pe	Range	Mean % Pe
Estimated Infected by Gender								
Male	1845-3070	0.73%	2410-3806	0.90%	2040-3200	0.76%	--	--
Female	235-376	0.09%	342-540	0.13%	290-460	0.11%	--	--
							--	--
Estimated Infected by Race								
Whites	1298-2078	0.44%	1778-2807	0.60%	1510-2350	0.50%	--	--
African Americans	405-649	1.55%	532-840	2.00%	450-710	1.71%	--	--
Hispanics	264-423	0.26%	323-511	0.29%	270-430	0.23%	--	--
APIs/Other	112-180	0.12%	119-187	0.11%	100-160	0.09%	--	--
							--	--
Estimated Infected by Risk Group								
Male Sex w/ Male	1233-1975	15.8%	1710-2700	22.1%	1680-2520	20.1%	--	--
Injection Drug Use	433-693	16.8%	367-579	18.3%	360-540	15.6%	--	--
MSWM/IDU	150-239	n/c	271-427	n/c	200-300	n/c	--	--
Heterosexual Contact	123-197	n/c	199-314	n/c	144-216	n/c	--	--
Estimated Total	**2080 - 3330**	**0.40%**	**2753-4346**	**0.50%**	**2400-3600**	**0.43%**	**1500-2100**	**0.26%**
Known PLWAs	**527**	**--**	**556**	**--**	**594**	**--**	**556**	
HIV+ / Pre-AIDS	**1553 - 2803**	**0.32%**	**2197-3790**	**0.43%**	**1806-3006**	**0.34%**	**944-1544**	**0.18%**

Pe=Prevalence

Data: San Mateo Health Services Agency, 1994, 1996, 1997. CA DHS AIDS Update Vol.10:1, 1997.

SAN MATEO COUN[illegible]IDS PROGRAM
CLIENT DEMOGRA[illegible]S BY PROVIDER COMPARED TO
CUMULATIVE AND LIVING AIDS CASES
for the period 4/1/98 - 2/28/99

GENDER	CUMULATIVE AIDS CASES	LIVING AIDS CASES	SMCAP	ATTENDANT CARE	FOOD PROGRAM	COMM. CARE DENTAL	RESIDENTIAL SERVICES	SUB. ABUSE TREATMENT
Male	89%	84%	74%	68%	70%	66%	61%	76%
Female	11%	16%	25%	29%	29%	23%	37%	22%
Transgender	0%	0%	1%	3%	1%	0%	2%	2%
Unknown	0%	0%	0%	0%	0%	11%	0%	0%
TOTAL	100% (N=1772)	100% (N=657)	100% (N=564)	100% (N=38)	100% (N=231)	100% (N=106)	100% (N=167)	100% (N=63)

AGE	CUMULATIVE AIDS CASES	LIVING AIDS CASES	SMCAP	ATTENDANT CARE	FOOD PROGRAM	COMM. CARE DENTAL	RESIDENTIAL SERVICES	SUB. ABUSE TREATMENT
12 Yrs. or Less	0.40%	0.46%	2%	0%	1%	1%	1%	0%
13-19 Yrs.	0.11%	0.15%	0%	0%	0%	0%	0%	0%
20-29 Yrs.	13%	12%	7%	5%	19%	6%	5%	10%
30-39 Yrs.	42%	46%	36%	39%	30%	45%	37%	44%
40-49 Yrs.	27%	32%	38%	26%	26%	36%	45%	38%
50 Yrs. or more	16%	10%	16%	29%	23%	12%	13%	8%
TOTAL	100% (N=1772)	100% (N=657)	100% (N=564)	100% (N=38)	100% (N=231)	100% (N=106)	100% (N=167)	100% (N=63)

ETHNICITY	CUMULATIVE AIDS CASES	LIVING AIDS CASES	SMCAP	ATTENDANT CARE	FOOD PROGRAM	COMM. CARE DENTAL	RESIDENTIAL SERVICES	SUB. ABUSE TREATMENT
White	65%	60%	42%	42%	22%	27%	28%	24%
African American	17%	19%	34%	34%	61%	30%	49%	63%
Latino/a	12%	14%	18%	21%	16%	20%	21%	11%
Asian/Pacific Islander	5%	6%	3%	3%	1%	4%	1%	0%
Native American	0.23%	0.30%	1%	0%	0%	2%	1%	2%
Other/Unknown	0%	0%	3%	0%	0%	17%	4%	0%
TOTAL	100% (N=1772)	100% (N=657)	100% (N=564)	100% (N=38)	100% (N=231)	100% (N=106)	100% (N=167)	100% (N=63)

ANNUAL INCOME	CUMULATIVE AIDS CASES	LIVING AIDS CASES	SMCAP	ATTENDANT CARE	FOOD PROGRAM	COMM. CARE DENTAL	RESIDENTIAL SERVICES	SUB. ABUSE TREATMENT
$7,200 Or Below	NA	NA	36%	45%	27%	42%	31%	68%
$7,201 - $10,800	NA	NA	26%	50%	59%	23%	45%	21%
$10,801 - $24,000	NA	NA	21%	0%	12%	15%	13%	6%
$24,001 - $28,800	NA	NA	2%	0%	0%	8%	11%	3%
Above $28,800	NA	NA	4%	3%	0%	0%	0%	2%
Uknown	NA	NA	10%	3%	3%	11%	0%	0%
TOTAL	NA NA	NA NA	100% (N=564)	100% (N=38)	100% (N=231)	100% (N=106)	100% (N=167)	100% (N=63)

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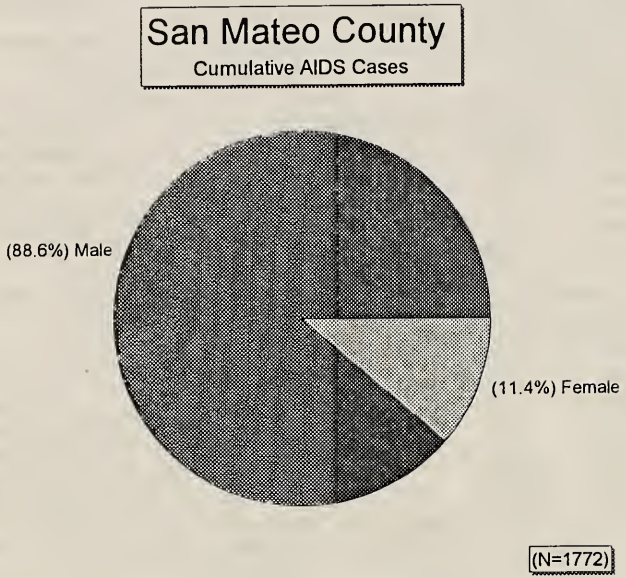
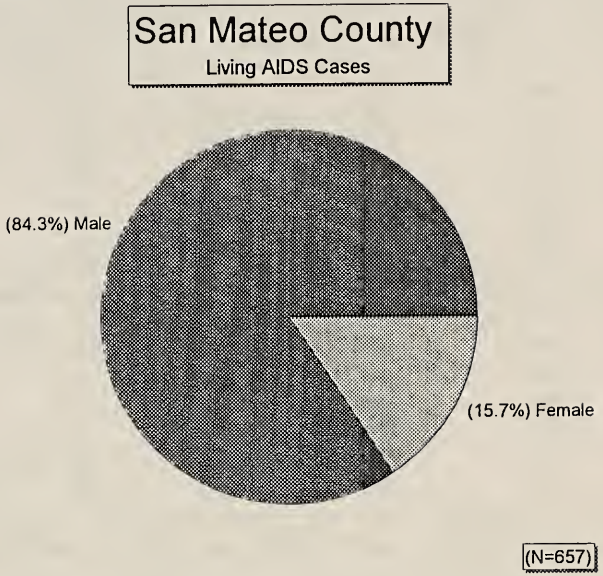
SAN MATEO COUNTY AIDS PROGRAM

Cumulative and Living AIDS Cases by Gender
for the period 4/1/98 - 2/28/99





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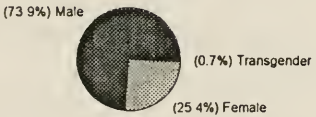
SAN MATEO CO TY AIDS PROGRAM

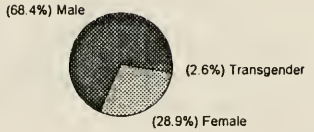
GENDER OF CLIENTS BY SERVICE PROVIDER
for the period 4/1/98 - 2/28/99

San Mateo County AIDS Program
Gender



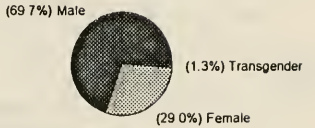
(N=564)

Attendant Care
Gender



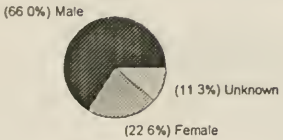
(N=38)

Catholic Charities Food Program
Gender



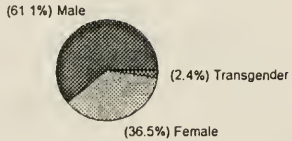
(N=231)

Community Care Dental
Gender



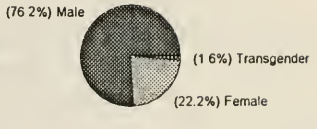
(N=106)

Residential Services
Gender



(N=167)

Substance Abuse Treatment
Gender

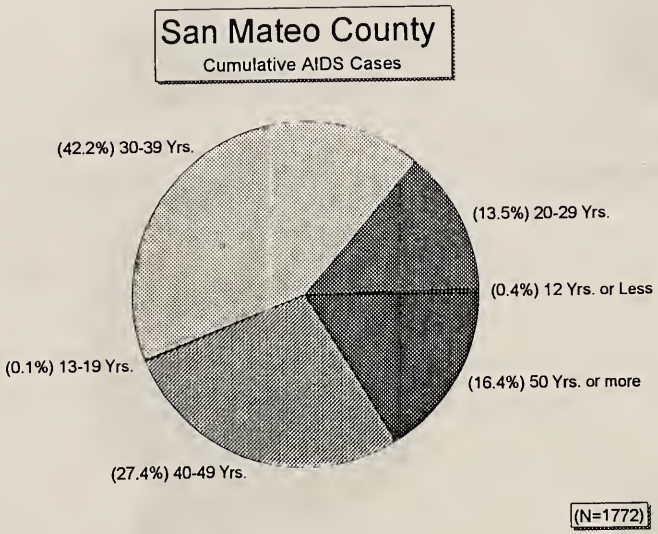


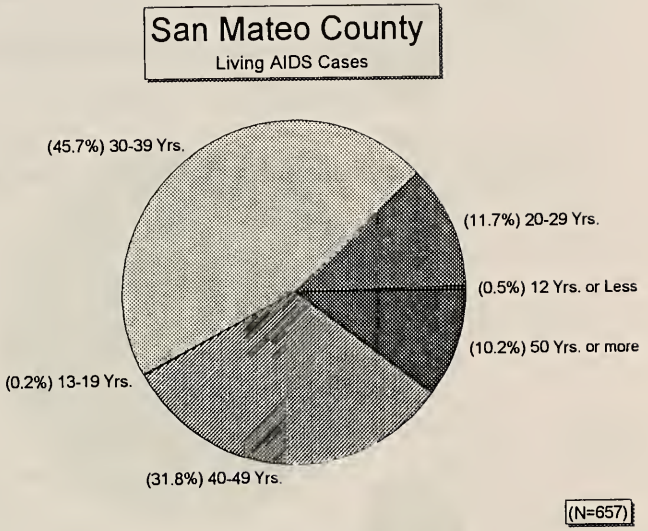
(N=63)

DEMO2 WK4

SAN MATEO COUNTY AIDS PROGRAM

Cumulative and Living AIDS Cases by Age
for the period 4/1/98 - 2/28/99

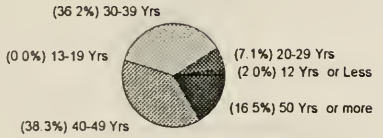




SAN MATEO COUNT[illegible]DS PROGRAM

AGE OF CLIENTS BY PROVIDER
for the period 4/1/98 through 2/28/99

San Mateo County AIDS Program
Age



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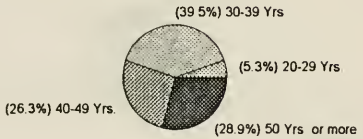
Attendant Care
Age



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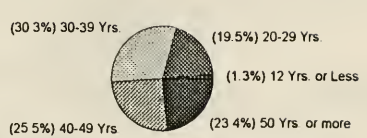
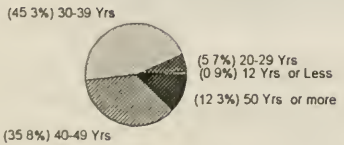
Catholic Charities Food Program
Age



(N=231)

Community CARE Dental
Age



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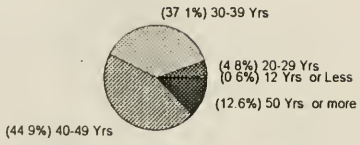
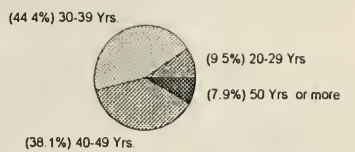
Residential Services
Age



(N=167)

Substance Abuse Treatment
Age



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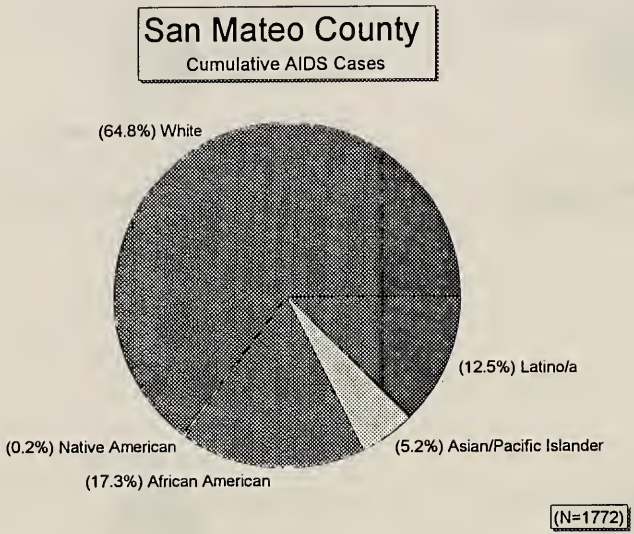
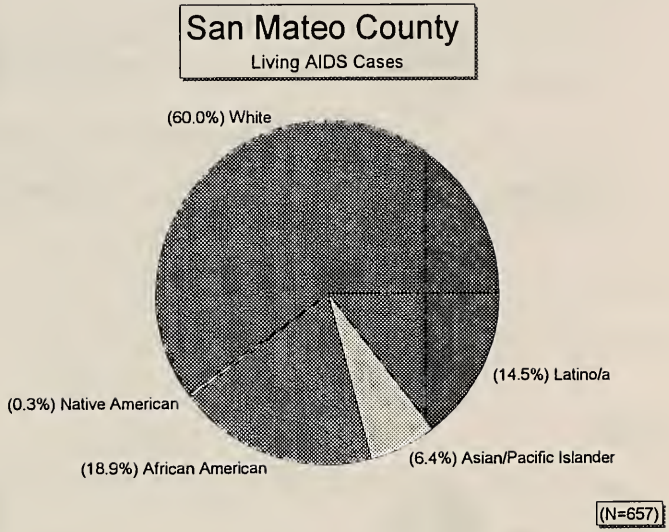
DEMO2 WK4

SAN MATEO COUNTY AIDS PROGRAM

Cumulative and Living AIDS Cases by Ethnicity
for the period 4/1/98 - 2/28/99

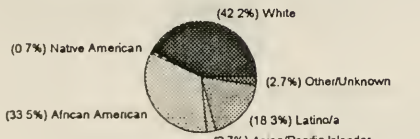




SAN MATEO COUNTY AI[illegible]ROGRAM

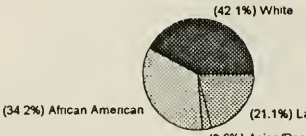
ETHNICITY OF CLIENTS BY PROVIDER
for the period 4/1/98 through 2/28/99

San Mateo County AIDS Program
Ethnicity



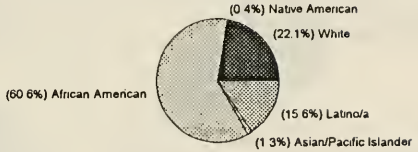
(N=584)

Attendant Care
Ethnicity



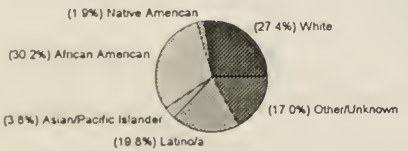
(N=38)

Catholic Charities Food Program
Ethnicity



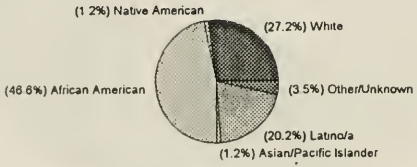
(N=231)

Community CARE Dental
Ethnicity



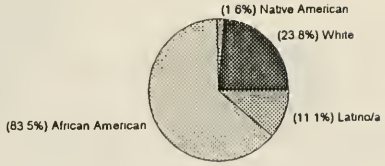
(N=106)

Residential Services
Ethnicity



(N=167)

Substance Abuse Treatment
Ethnicity

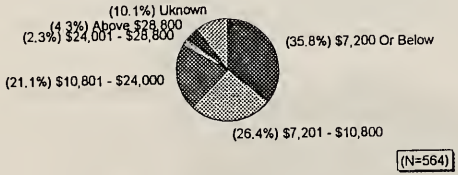


(N=63)

SAN MATEO COUNTY AIDS PROGRAM

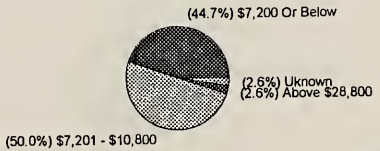
ANNUAL INCOME OF CLIENTS BY SERVICE PROVIDER
for the period 4/1/98 - 2/28/99

San Mateo County AIDS Program
Annual Income



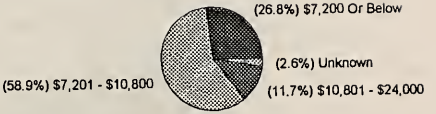
(N=564)

Attendant Care
Annual Income



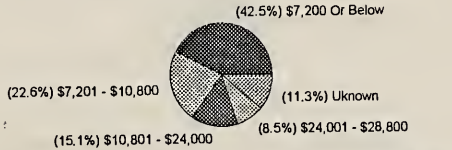
(N=38)

Catholic Charities Food Program
Annual Income



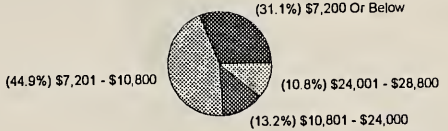
(N=231)

Community CARE Dental
Annual Income



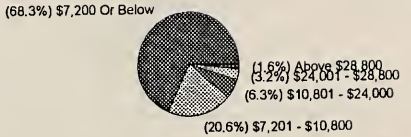
(N=106)

Residential Services
Annual Income



(N=167)

Substance Abuse Treatment
Annual Income



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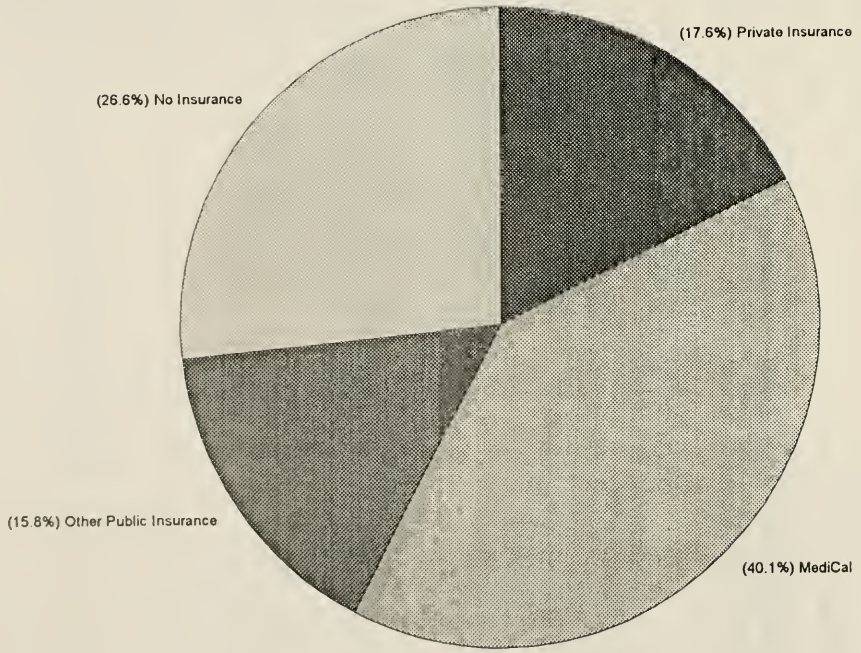
SAN MATEO COUNTY AIDS PROGRAM CLINIC

Insurance Status of Clinic Patients

for the period 4/1/98 - 2/28/99



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SAN MATEO COUNTY AIDS PROGRAM
SUMMARY FOR PERIOD 3/1/1999 THRU 2/29/2000

SERVICE CATEGORY	DIRECT EXP.	IND.COSTS	TOTAL	IND.RATE
I. Primary Care/Early Intervention	671,382	67,138 *	738,520	0.10
II. Housing				
1. Residential Assistance	95,422	8,588 **	104,010	0.09
III. Food	183,486	16,514 **	200,000	0.09
IV. Dental	161,357	14,522 **	175,879	0.09
V. Mental Health	65,997	5,940 **	71,937	0.09
VI. Substance Abuse	182,805	18,281 *	201,086	0.10
VII.Case Management	354,562	35,456 *	390,018	0.10
VIII. Client Advocacy				
1. Health Outreach Team	264,782	26,478 *	291,260	0.10
2. Benefits Counseling	96,750	9,675 *	106,425	0.10
TOTAL RYAN WHITE TITLE I	2,076,543	202,592	2,279,135	0.0976

* Indirect Costs to SMCAP for programs provided
**Indirect Costs to Contract Agency providing the service

NOTE: Nutritional Counseling is included in primary care.
Health Education and Client Transportation are included in Case Management
Support Groups are included in Mental Health
Summary includes $126,303 in Ryan White II funding

I. **Call to Order**
4:30 PM

II. **Roll Call**
Attachment A, Column I

III. **Review and Approval of Agenda**
LC-G asked that it be put off, as she has not had time to review the agenda

IV. **Review and Approval of Minutes**
Minutes of 5/24/99 were approved. Abstentions: *SJ, NN, AR, JB* and *TL*

V. **General Announcement**
LCG and *TC* reported back on a meeting held with Bill Barnes and Steven Kawa to finalize negotiations on membership criteria (**Attachment B**). She will be contacting each member individually to go over their status and the impact of these decisions on their status. Several persons asked questions about individual people's status, including *LO* and *JC*.

Michael Moors distributed the new July calendar.

Laura Thomas distributed several documents including Quarterly Surveillance Report, selected statistics from HIV Epidemiology Report, the HRSA Newsletter, and the Care Coalition's policy position paper as she reported in the last meeting. She also announced that a 2% per year step-down had been decided upon rather than the complete elimination of the Hold Harmless Formula. Finally she distributed a document on appropriate use of data for prioritization setting.

LO'C announced the death of Carol Saporian, a member of the community in the East Bay, member of W.O.R.L.D.

VI. **Public Comment**
Teresa Gallegos representing the Family Focused Care Committee of the Children's System of Care Planning Council, distributed a document (**Attachment C**) and asked that the Council take into consideration the needs of families as a whole and the special needs that family's have in healthcare.

Sean Brooks of SF Food Bank asked that the Council consider that money potentially earmarked for food vouchers be given to them since they purchase food for less than the supermarkets and they distribute directly to ASO's.

VII. **Mayor's Liaison Report**
Bill Barnes being absent, *NR* proposed to postpone the Mayor's Liaison Report until later

VIII. **Co-Chair Report**
NR suggested *Michael Moors* explain a change in public notification process. *Michael* explained as per his document dispatched this month according to the City Attorney Office upcoming meeting dates and times must be accompanied by a brief agenda. *TL* added that they must be comprehensible for any member of the public and that any votes be mentioned.

DJ explained that some work done by the Support Center for Non-Profit Management (fiscal agent for support staff and Reggie) covered several fiscal years. Generally the DPH put forward these sums until the money arrived. The DPH have announced that this money must be reimbursed and if not this will have on impact on funds earmarked for the Consumer Right's Advocate Position and the Needs Assessment. Therefore the steering committee has decided to put a total of $269,000 into the request for rollover funds in order to meet these obligations. This budget will be voted later on during the meeting.

IX. Membership Committee Report

TC announced that the Attendance Review had been stricken from the agenda, as the committee had not had the time to prepare this. *LCG* announced the resignation of *Chris Boehm*. She referred to **Attachment B**, which covers the new conditions, decided in collaboration with the Mayor's office. She explained that the committee would be reviewing nominations in light of these new conditions and particularly once she had received intentions to re-apply for those whose terms are ending. As of this day, eight new positions are open, five are pending (the June nominations), and the following groups are under-represented according to quotas: HIV+ persons, blacks and consumers. She presented nominations of two new candidates, Sister MaryMac Himm and Jim Mitsulki (short biographies appear on Attachment I) to be forwarded to the mayor's office for approval.

The council voted to approve these two memberships (Attachment A, Column 2)

X. Prioritization Timeline for June/July/August

DJ presented the new calendar modified in order to accommodate the prioritization process. Two council meetings will be organized in July. She will attempt to set the July 12 at 25 Van Ness from 4:30 to 7:30 rather than at City Hall from 5:30 to 8:30. She added July 19, a special meeting for the co-chairs of the prioritization groups and co-chairs of the council in order to pull the individual groups' work together. Dinner will be provided. The dynamic will be a work meeting although public debate will take place in the beginning. The steering committee will not meet in July. The July 26 Council will include a report from this meeting as well as a report from San Mateo and Marin Counties.

XI. Request for Rollover of unliquidated FY 98-99 funds for HRSA

Michelle Dixon-Long presented a document (**Attachment D**) which is the AIDS Office formulation of the Council's proposals for unliquidated funds, a.k.a., Rollover Funds. *TC* had already insisted on the fact that this was a request and that the process could be lengthy, thus the necessity to vote rapidly.

Discussion:
TC explained that Line 6B corresponded to an experience recounted by someone participating in the Housing Prioritization Work Group which needed to be worked out in detail. He explained the general idea being to unblock funds for emergency eviction prevention actions.
NN feared that the notion of loan would probably not be accepted by HRSA due to the fact that it may span more than one fiscal year, thus a need to propose a second option.
LO'C asked that the trainings in Line 9 also address Case Managers, Peer Advocates and Spanish Speaking people.
LC-G asked that the training be on Harm Reduction and SSI/Medi-Cal Benefits
Michelle Dixon-Long distributed a list of the recent needs in TA and Training expressed by contractors (**Attachment E**).
A discussion around Line 12 ensued. *SJ* wanted a clearer system of accountability for prisoner release. *SS* insisted on the fact that this was for non-ADAP drugs and felt it was not the council's priority.
MJW made a proposal that the document be accepted as such.
SS made a motion to amend the proposal by canceling Line 12 and putting the amount indicated into Line 2.
Gary Levinson (Project Reggie) explained it might be difficult to spend all of the money within the allotted time period.
AR made a motion to put the funds form Line 12 into Housing B, Line 6
NN argued against one-time funds for housing, preferring to use it for Reggie and, if the computers cannot be used for Reggie, stipulated that they could always be used by ASO's.
TL was opposed to putting the money into housing and felt that, as a consumer, non-ADAP drug access was a definite problem for him.
DB asked for a clarification around the idea of revolving loans
TC explained that it was for persons not eligible for housing assistance and at risk of eviction or not attaining housing. The thrust of the project was to offer free funds or a loan depending

on the financial abilities of the client.
Michelle also communicated a need for $100,000 of vouchers for household goods.
DB made a motion to use $100,000 of the $135,00 toward this with the $35,000 left over to go towards Line 6B. The motion was not seconded.

AR made "*a motion to put the $135,OOO from Line 12 to be applied to Line 6*"
The Council voted not to move the funds from Line 12 to Line 6 (Attachment A, column 3)
SS made "*a motion to put the $135,OOO from Line 12 to be applied to Line 2*"
The Council voted not to move the funds from Line 12 to Line 2 (Attachment A, column 4)
TC proposed the decision be cut in half and made "*a motion simply to take out the $135,OOO from Line 12*"
The Council voted not to take ont the $135,000 from Line 12 (Attachment A, column 5)
TC proposed "*a motion to approve the budget as presented.*"
The Council voted to approve the budget as presented on Attachment V

XII. Needs Assessment Presentation

EW, co-chair of the Needs Assessment Task Force introduced the speakers and thanked a certain number of participants for their help/support on this project.
Gary Levinson of the Support Center for Non-Profit Management introduced the findings by explaining the following general themes:
- Very extensive data, can be used over the next two or 3 years
- The research team will be available for priority setting workgroups from June 29 to July 12
- Final Report will be presented on July 12

A. Qualitative Findings
Steve Lew, also of the SCNM presented the general findings of the Qualitative Aspect, insisting on the fact that these were:
- based on purpose over-sampling for certain groups as per the NATF's requests
- subjective since based on clients own perceptions as expressed in focus groups
- in response to questions on how people were experiencing the service system and how it met or didn't meet their needs.
- presented in form of Main Themes, subjects which appeared transversally

1. Health Status
- clients doing well
- physical problems are linked with drugs
- mild to severe depression
- Mental health problems are linked to Health problems

2. Treatment Status
- Significant portion not taking HAART, because of:
- side effects
- quality of life issues
- skepticism as to efficacy

3. Needs
- Most needs have been met
- The notable exception is housing

4. Housing
Overwhelming unmet needs:
- lack of available housing
- unhealthy SRO's
- lack of "stabilizing services", i.e.,
-- bat ng facilities
-- storage facilities
-- moving services

5. Population-specific Needs
Women and women with children
heterosexuals

Immigrants (fear of INS)

6. Other Unmet Needs
-money management services
- transportation vouchers
- job bank
- legal services for immigrants

7. Barriers to Service
Information about Treatments
- difficult managing information
- complexity of the information

Information about Services
- providers unclear about other services
- case management and peer advocacy not readily available everywhere

Other Barriers
Waiting Lists
- particularly for housing
- sometimes in clinical settings

Long Waiting Times
- Drs offices
- case managers

Specific populations feel discriminated against in some settings

8. Quality of Care
Very positive, appropriate depth and breadth
Many people expressed, "I love my doctor, he/she loves me"

But, lack of coordination
Inclusion criteria are not always adapted to clients needs

Illustrated by this quote: "The main theme used to be COMPASSION now it's RULES"

9. Needs for Improvement
In service Delivery:
- lack of respect
- high level of bureaucracy
- no racial diversity among staff/culturally insensitive
- territory/turf issues around clients
- lack of compassion/empathy
- slips in confidentiality
- few PWA/HIV working in services

10. Reggie
- mixed feelings about it
- wonder why all agencies aren't on it
- wonder why some agencies don't use it properly

11. Clients Seeking to Connect with Others
- many clients volunteer in an agency to help other PWA's, to share the experience
- an unmet need to connect with peers, i.e. peer groups
- many new arrivals in SF looking to connect with other PWAs

12. Entry/Return to Work
- fear of losing benefits, fear of discrimination
- too much bureaucracy
- not wanting to return to work

Discussion:
LO'C asked more specifics on women's needs as well as around substance use issues. The former were around their difficulties taking children into certain activities i.e. support groups and lack of chil[illegible]are, as well as food vouchers and transportation. The latter was not really brought up. Researchers indicated a lack of dialog around Substance Use Services as a general rule even though substance use as a subject was very present.
TL asked why 31% were heterosexual. This was part of the oversampling policy.
LCG asked about money problems. Many people mentioned lack of money to pay for drugs, particularly painkillers
MS asked about the social needs. Researchers found participants starved for interaction with peers, were struck by the fact that the participants mentioned wanting providers to be PWA's.
SS asked about insurance needs. No findings informed on this theme in particular.

B. Quantitative Report
Michael de Mayo of Harder+Company Community Research began presenting the quantitative data by also insisting on the fact that it could be used over several fiscal years as it was very rich. He first distributed a list of the agencies in which surveyors had collected data (**Attachment F**). He then used (**Attachment G**) as the basis of his presentation and the logic behind the questionnaire. Pages 7 through 10 indicate some findings around medication and housing, two themes the Task Force particularly asked about. These pages also give an example of how this data can be used, in this case, it presents two categories: housing needs and African-Americans surveyed.

He then presented the following methodology:
25 Persons with HIV/AIDS were recruited and trained to conduct the surveys
44 sites opened their doors to survey takers
968 surveys were conducted
856 in SF County
112 in San Mateo County
The purposely-oversampled populations were: Women, African Americans and People "out of care". Michael explained that the latter were very hard to find given the methodology and recruitment methods.
The period covered by the questions was the last four months.

General Conclusions
There is a high level of met needs
There are pockets of high level unmet needs, Housing for Blacks being one of them
Dental Care is an unmet need for all groups surveyed
Home Health Care needs are not being met by those who express the need.

Michael insisted on the fact that he would be available with a computer to "run" specific research in Prioritization Work Groups until July 12.

All CARE Council & Committee meetings are held in accessible sites, and are open to members of the public. Participation [illegible]eople living with HIV is strongly encouraged. Minutes of meetings and all information distributed to Council members [illegible]available for public inspection and copying. For further information contact Council staff at 415/554-9136

Attachment A.

HIV Services Planning Council

Roll Call [1]: P=Present; A=Absent; E=Excused; L=Leave of Absence
Votes [2-4]: Y=Yes; N=No; B=Abstain

6/28/99		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	*KB*	A											
Dorothy Bartolomucci	*DB*	L											
Donald Bliss	*DCB*	P	B	N	N	Y	N						
Jeff Byers	*JB*	P	Y	Y	Y	Y	Y						
Virginia Cafaro	*VC*	A											
Tom Calvanese	*TC*	P	Y	Y	N	Y	N						
Bart Casimir	*BC*	A											
Veronika Cauley	*VC*	E											
Julie Charubusapayon	*JAC*	A											
John Conley	*JC*	P	Y	N	N	N	Y						
Luis De La Torre	*LDT*	E											
Mark Dunlop	*MD*	P	Y	N	N	N	Y						
Gene Gowdey	*GG*	A											
Laura Guzmán	*LCG*	P	Y										
Siddiq Jihad	*SJ*	P	Y										
Darrell Joe	*DCJ*	A											
Diane Jones	*DJ*	P	Y	Y	N	Y	Y						
Samuel Kaplan	*SK*	P	Y	Y	N	Y	Y						
Tony Leone	*TL*	P	Y	N	N	N	Y						
Allen Meyer	*AM*	P	Y	Y	N	Y	Y						
Lee Ann Monfredini	*LM*	A											
Norm Nickens	*NN*	P	Y	N	N	N	Y						
Lisa O'Connor	*LO'C*	P	Y	Y	N	Y	Y						
Loras Ojeda	*LO*	P											
Jorge Ortiz	*JO*	A											
Stephan Oxendine	*SO*	E											
Alissa Riker	*AR*	A	Y	Y	Y	Y	N						
Nilda Rodriguez	*NR*	P	Y	Y	N	Y	Y						
Matthew Sharp	*MS*	P	Y	Y	N	N	Y						
Susan Shea	*SS*	P		N	Y	Y	Y						
Kelly Wallace	*KW*	P	Y	N	N	Y	Y						
Eric Whitney	*EW*	P	Y	N	N	Y	Y						
Mary Jane Wood	*MJW*	P	Y	N	N	N	Y						

ATTACHMENT B

HIV Health Services Planning Council
Membership Committee

Report, June 28th, 1999

1. Meeting with Steve Kawa, Mayor's Office Director of Legislative Affairs

Tom Calvanese, Bill Barnes and I met wit Mr. Kawa on June 23 to finalize our discussion and reach an agreement concerning Membership Terms. In this meeting, Mr. Kawa and us reached agreement on the following issues:

- Mayor agreed that beginning November of 1998, Council members should serve 2-year terms, thereby honoring our by-laws change.
- Mayor agreed to honor Council's date of appointment for each Council member as reflected on Attachment B (see June Report-Membership Committee); March 1999 letters to Council Members from the Mayor are therefore void.
- Mayor believes it cannot apply by-laws retroactively due to potential policy implications.
- For those members whose terms are close to expire/have expired:
    - You will have the opportunity to apply for a new 2-year term AND
    - You will continue to serve out your current term until a determination has been made concerning any requests to serve an additional term (according to the agreement, new end of term = last day of the month)

Members will be contacted individually concerning the implications of this agreement by Membership Chair. Membership will be distributing by special mailing a new list with the new dates of "end of term" for each Member, along with copies of the official communication from the Mayor's office, once it is received.

2. Review of Applications

On June 8, 1999, the Membership committee met to review the applications that have been submitted to date to the Council and made the following recommendations for Appointments:

Sister MaryMac Himm is a 33-year old HIV+ Caucasian, gay male who is a local community leader and activist. Sister MaryMac community work includes his volunteer activities with the Sisters of Perpetual Indulgence and his membership on the HIV

Prevention Planning Council (HPPC). Sister MaryMae chairs the HPPC's Strategic Evaluation Committee. After 15 years of HIV prevention work, Sister is very interested and committed to act as a bridge between the HPPC and our HIV Service Council.

Jim Mitulski is a 41 year-old, HIV+ Caucasian, gay male, who has worked for 14 years as a pastor for the Metropolitan Community Church (MCC) in the Castro district. In addition to his pastoral and social service through MCC, Jim has also been a member of the G/L/B/T Task Force of the San Francisco Human Rights Commission. He is committed to coalition building and to represent the faith community on the Council.

The applications of Aracely Salazar, Gregory Neumark and Salvador Vera were deferred pending the appointment of Council members recommended to the Mayor on June 7, 1999, and the resolution of other membership issues. They will be contacted individually and encouraged to attend the next Membership Committee meeting on July 6, at which time the committee will consider their applications in the context of the current Council membership.

ATTACH C

"Families are expert partners in planning treatment and making decisions."

- Embrace each client's definition of family and community.
- Respect your client's role as mother, father, grandparent, son, daughter, brother....
- Listen to, provide options, and encourage parents -- but respect that the ultimate choice is theirs.
- Work with and respect family caregiver's decisions on how to discuss problems with their children.
- Enable teamwork, but accept the limits of service integration and provider selection a family desires.

"Help us keep our family together, safe and healthy. Do not put our family on hold."

- Provide an atmosphere that is safe and nurturing in times of crises.
- Create goals and treatment plans for families as well as for individual clients.
- Make out-of-home placements for children the absolute last measure of resort.
- Provide in-home respite support.
- Arrange consistent and frequent family contact and support during times of crises.
- Arrange transportation for visits to family members who are hospitalized. Arrange phone contact for family members unable to visit.
- Enable your agency to respond to the family's needs for support, resources, and/or advocacy.
- Provide activities for families that develop independence, resourcefulness and community-building, e.g., self-advocacy, tutoring programs, peer support groups, parent/teacher conferences, dances, celebrations of accomplishments, community-organizing, etc.

"When our children are cared for in a way that makes us feel safe, our efforts to start and stay in treatment will be successful."

- Not bringing children to appointments may not be an option. Create childcare options for parents to choose from.
- Respect the childcare choices and arrangements of a family.
- Provide a safe area for children at your facility.
- Do not assume that older children can be relied upon for childcare or that they can amuse or entertain themselves.
- Provide childcare options to families throughout the course of treatment, for example, during home visits, off-site appointments, intakes and other pre- and post-program sessions

"When we come to you for help, we come for hope."

- Encourage and build on positive behaviors.
- Assess families based on strengths and potential.

"Transitions are difficult. Help us make this journey smooth."

- Allow sufficient time for families to adjust to new providers before completely ending yours.
- When families finish or move to new levels within a program, prepare them and inform them of what is to come and how to deal with change.
- Provide resources after a program ends for making referrals, providing information and resource lists, responding to a family's call for support, etc.

"No matter how good the program or treatment plan is, if we cannot get there it does us no good."

- Offer flexible treatment time-slots and flexible office hours. Respect a family's time-management issues.
- Remain flexible when creating rules and expectations: keep in mind that a family may have many commitments and that unexpected obligations often arise that must take precedence over an appointment with you.
- Provide transportation options.

"Commit yourself and your organization to Family Focused Care."

- Commit to having consumers and their families help implement this proposal.
- Train your staff in family-focused care principals.
- Commit to employing past and present consumers.
- Train your staff to handle an array of physical, mental, and learning disabilities.
- Negotiate to stretch the cost of your unit of service to include family services, not just individual.
- Train your staff with the help of past and current consumers of services.
- Allow staff sufficient time and build incentives for staff to work with families who have complex and intensive needs.
- Prepare your staff to acknowledge and deal with the different cultures, beliefs, and values that may exist between them and the families they see.
- Have parents and current consumers formally involved in program evaluation and policy development
- Commit to social education...for understanding the history and politics of poverty is an important part of healing.

This Message has been brought to you by the
Family Focused Care Committee of the Children's System of Care Planning Council
San Francisco Department of Public Health

st Edition – April 1999

415-970-3860

ATTACH D

File Name: u:\wp\Fiscal\PRIORTY3.xls
Date: 6/28/99

DRAFT FOR APPROVAL

PRIORITIZATION OF UNLIQUIDATED BALANCE FROM FY 98-99

		COST
1 Planning Council Support		$129,001
2 Reggie Project Equipment		$140,278
3 Augmentation of the CBC initiative to include Latinos		$45,185
4 Direct Emergency Financial Assistance		$700,000
5 Housing (A)		$210,000
Emergency Housing Vouchers	*$80,000*	→ 161 clients
Security Deposits for rental units	*$100,000*	→ 83 clients
Residential Housing appliance upgrades	*$30,000*	≈ → 58 stoves, 35 fridges
6 Housing (B) Revolving Loan Fund		$143,268
7 Food Vouchers		$58,030
8 Childcare Insurance		$1,500
9 Provider trainings by the AETC		$80,150
Transgender Community Medical Needs	*$21,057*	
HIV Cognitive/Motor Complex	*$21,104*	
Primary Care Chart Review Protocol Development	*$37,989*	
10 Outreach and program promotion campaigns		$60,000
11 Computers equipment/software for Marin Co.		$25,803
12 Forensic Pharmacy Services		$135,000
Total Unliquidated Balance		$1,728,215

ATTACH E

Created: 4/15/99
Revised: 6/28/99

DRAFT

TECHNICAL ASSISTANCE WORKSHOPS/NEEDS

1. Supervision Skills, especially dual supervision of one employee
2. Progress Note writing
3. Integration of data systems and REGGIE
4. Training providers to assist clients in obtaining SSI
5. Program Evaluation methods: Training in the evaluation of outcome and impact objectives; link to tracking of adherence
6. Case Management Standards workshop
7. Staff Recruitment and Retention methods
8. Development of Service Contingency plans
9. Counseling Skills
10. Communication Skills and Techniques, especially with integrated or linked services
11. Effective utilization/training of Peer Advocates
12. Advocacy for incarcerated clients and recidivism prevention
13. Education/encouragement to landlords renting to HIV+ clients, esp. in the SVHP

ATTACH F

San Francisco EMA Needs Assessment
Interview Locations

Project Open Hand	96
Tenderloin AIDS Resource Center	94
Ward 86	60
Tom Waddell Health Center	48
Continuum HIV Day Services	46
Walden House	44
AIDS Health Project	40
Derrick Silva Community, Catholic Charities	38
Lutheran Social Services	37
Other	35
Edison Clinic	34
Shanti	29
Baker Places	25
San Mateo County Offices Willow Clinic	22
Glide Goodlett	21
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Leland House	18
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Quan Yin	15
API Wellness Center	14
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OASIS	12
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University of the Pacific School of Dentistry	10
Brandy Moore House	9
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Haight Ashbury Free Clinic	8
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Maitri	8
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Native American AIDS Project	7
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BAY Positives	5
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Clinica Esperanza, Mission Health Center	4
Episcopal Community Services	4
Lodestar	4
Urban Health Study	3

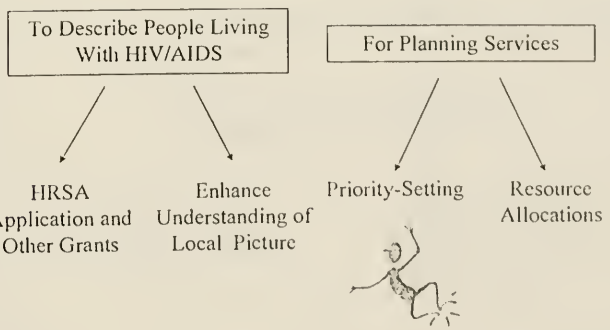
ATTACH G

Needs Assessment Survey Findings

Detailed Information About 10 Services and the People Who Use Them

- Primary Medieal Care
- Case Management
- Mental Health Serviees
- Substanee Abuse Services
- Home Health Care
- Food Services
- Housing Assistanee
- Transportation Services
- Dental Care
- Complementary Treatments

How Can You Use this Information?



Where Do the Numbers Come From?
Service Priorities

For cach service, the Survey asked if people needed it in the past four months.

Primary Medical Care Example:

In the past four months, did you need to see a doctor or other health care provider, including your regularly scheduled appointments? → Overall, 75% Say "YES," I have needed medical care.

Where Do the Numbers Come From?
Unmet Need

For people who reported needing a service, the Survey asked if they could get that service when they needed it.

Primary Medical Care Example:

In the past four months, when you needed to see a doctor or other health care provider, did you receive services? → Overall, 3% said "NO," they did not get primary medical care services when they needed it.

Where Do the Numbers Come From?
Unsatisfied Need

For people who received a service, the Survey asked if the services they received met their needs.

Primary Medical Care Example:

Did the services you received meet your needs? ⟶ Overall, 5% said "NO," the services they received did not meet their needs.

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Service Priority Ranking — Overall (n=968)

PRIORITY RANKING	SERVICE	OVERALL
1	Primary Medical Care	76% (n=736)
2	Case Management	60% (n=581)
3	Dental Care	52% (n=503)
4	Housing	49% (n=474)
5	Food Assistance	49% (n=472)
6	Mental Health Services	38% (n=372)
7	Transportation	37% (n=363)
8	Substance Abuse Services	36% (n=348)
9	Complementary Treatments	24% (n=232)
10		15% (n=140)

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo - Services Ranking/Unmet Need (n=968)

SERVICE	OVERALL	UNMET NEED
Primary Medical Care	1. 76% (n=736)	9. 3% (n=21)
Case Management	2. 60% (n=581)	6. 8% (n=45)
Dental Care	3. 52% (n=503)	1. 38% (n=177)
Housing	4. 49% (n=474)	2. 29% (n=137)
Food Assistance	5. 49% (n=472)	10. 3% (n=15)
Mental Health Services	6. 38% (n=372)	7. 7% (n=24)
Transportation	7. 37% (n=363)	4. 20% (n=71)
Substance Abuse Services	8. 36% (n=348)	8. 4% (n=13)
Complementary Treatments	9. 24% (n=232)	5. 17% (n=36)
Home Health Care	10. 15% (n=140)	3. 27% (n=36)

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Unsatisfied Need

PRIORITY RANKING	SERVICE	NEED UNSATISFIED
1	Primary Medical Care	7% (n=46)
2	Case Management	10% (n=49)
3	Dental Care	13% (n=38)
4	Housing	13% (n=44)
5	Food Assistance	9% (n=36)
6	Mental Health Services	7% (n=19)
7	Transportation	5% (n=11)
8	Substance Abuse Services	7% (n=20)
9	Complementary Treatments	7% (n=12)
10		5% (n=3)

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Service Priority Ranking — County

SERVICE	Rank	San Francisco (n=841)	Rank	San Mateo (n=113)
Primary Medical Care	1	77% (n=648)	1	73% (n=82)
Case Management	2	61% (n=513)	3	50% (n=57)
Dental Care	3	52% (n=437)	2	53% (n=63)
Housing	5	50% (n=421)	2	53% (n=63)
Food Assi ce	4	51% (n=429)	4	47% (n=53)
Mental Health Services	6	41% (n=345)	7	25% (n=28)
Transportation	7	40% (n=336)	6	28% (n=32)
Substance Abuse Services	8	37% (n=311)	5	37% (n=42)
Complementary Treatments	9	25% (n=210)	8	10% (n=11)
Home Health Care	10	16% (n=129)	8	10% (n=11)

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Service Priority Ranking — Ethnicity

S	Af. Amer	White	Latino/a	Asian/PI	N.Amer.
Primary Medical Care	2	1	1	2	2
Case Management	3	2	2	1	2
Dental Care	4	3	5	5	3
Housing Assistance		5	3	3	1
Food Services	5	4	4	6	4
Mental Health Services	8	6	6	4	3
Transportation	6	8	7	5	5
Substance Abuse Services	7	7	8	8	7
Complementary Treatments	9	9	9	7	7
Home Health Care	10	10	10	9	6

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Unmet Service Need — Ethnicity

S	Af. Amer	White	Latino/a	Asian/PI	N.Amer.
Primary Medical Care	5% (n=14)	1% (n=4)	2% (n=1)	-	10% (n=2)
Case Management	8% (n=17)	8% (n=18)	8% (n=4)	5% (n=1)	15% (n=3)
Dental Care	41% (n=82)	35% (n=68)	23% (n=9)	33% (n=3)	60% (n=10)
Housing	29% (n=64)	29% (n=50)	29% (n=11)	50% (n=6)	17% (n=2)
Food Services	3% (n=6)	4% (n=8)	2% (n=1)	-	-
Mental Health Services	8% (n=10)	6% (n=9)	5% (n=2)	14% (n=2)	6% (n=1)
Transportation	22% (n=39)	17% (n=21)	18% (n=5)	33% (n=3)	27% (n=3)
Substance Abuse Services	2% (n=3)	6% (n=8)	8% (n=2)	-	-
Complementary Treatments	16% (n=11)	14% (n=15)	28% (n=5)	43% (n=3)	11% (n=1)
Home Health Care	36% (n=21)	22% (n=12)	10% (n=1)	50% (n=1)	11% (n=1)

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Service Priority Ranking — Gender

S	Male	Female	Transgender
Primary Medical Care	1. 77% (n=516)	1. 73% (n=145)	1. 78% (n=64)
Case Management	2. 58% (n=385)	2. 62% (n=123)	2. 72% (n=58)
Dental Care	3. 55% (n=364)	5. 43% (n=87)	4. 52% (n=42)
Housing Assistance	5. 51% (n=338)	3. 55% (n=110)	7. 33% (n=27)
Food Assistance	4. 53% (n=349)	7. 38% (n=76)	3. 56% (n=46)
Mental Health Services	6. 40% (n=266)	6. 40% (n=80)	8. 32% (n=26)
Transportation	7. 37% (n=245)	5. 43% (n=85)	5. 37% (n=30)
Substance Abuse Services	8. 35% (n=231)	4. 44% (n=88)	6. 34% (n=28)
Complementary Treatments	9. 24% (n=158)	8. 26% (n=53)	9. 17% (n=14)
Home Health Care	10. 14% (n=89)	9. 20% (n=39)	10. 15% (n=12)

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo -

Unsatisfied and Unmet Service Need for Women

S	U N	U N
Primary Medical Care	5. 6% (n=8)	10. 1% (n=2)
Case Management	6. 6% (n=7)	6. 7% (n=9)
Dental Care	1. 11% (n=5)	1. 44% (n=36)
Housing Assistance	2. 10% (n=7)	3. 26% (n=24)
Food Assistance	3. 9% (n=6)	7. 5% (n=4)
Mental Health Services	8. 2% (n=1)	8. 3% (n=2)
Transportation	7. 3% (n=2)	4. 10% (n=8)
Substance Abuse Services	4. 8% (n=6)	9. 2% (n=2)
Complementary Treatments	---	5. 10% (n=5)
Home Health Care	---	2. 33% (n=39)

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Medications - Summary of Findings

- **63%** of people with an AIDS diagnosis are currently taking HIV/AIDS medications.
- Women are less likely to be taking HIV/AIDS medications than male or transgender clients.
- MSMs and IDUs have the highest rates of medication taking among all transmission groups.

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Medications - Summary of Findings

- The most common reasons for stopping HIV/AIDS medications are:

- Bad side effects
- Too complicated to take
- Doctor's advice

- The most common reasons for never having taken HIV/AIDS medications are:

- Not needed/too healthy
- Fear of side effects
- Unstable living situation

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Currently Homeless - Summary of Findings

- 63% of PLWH who are currently homeless are *not* taking HIV/AIDS medications.
- African American/Black clients have the highest rate of homelessness of any racial/ethnic group. 52%
- 37% of currently homeless clients are injection drug users.
- 5% of families are currently homeless.
- 60% of PLWH under 25 years old are currently homeless.

A Sample of People Living with HIV/AIDS in San Francisco and San Mateo

Housing Summary - Need for Services

Characteristics of people who have the highest need for housing services (assistance locating housing or financial assistance for housing.)

- Those with an AIDS Diagnosis
- MSM or IDU
- Multiple diagnosed – HIV & MH & SUBSTANCE USE
- African American/Black or Caucasian
- Income of less than $900 per month
- SSI, SSDI, or GA as primary source of income

Housing Need Among African American Survey Respondents

- 52% of these respondents report that they are currently homeless.
- 44% are currently on the housing waiting list - a total of 191 people.
- 34% report needing help finding a place to stay in the past four months.

Housing Need Among African American Survey Respondents

- For those people who reported needing this assistance, 20% received no services.

Reasons for not receiving services:

-Didn't keep housing appointment
-Nothing available
-Too much red tape
-Past history

Housing Need Among African American Survey Respondents

- Services that respondents did receive include:

13% received shelter services
2% received permanent housing
7% received assistance locating housing
5% received transitional housing

Housing Need Among African American Survey Respondents

- Of those who received services, 15% reported that the services they received did not meet their needs.

Reasons why service needs were not met:

-Housing was not adequate

-Still homeless/still don't have a place to stay

-Too many limits on assistance

HIV HEALTH SERVICES PLANNING COUNCIL

SF
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#1
7/12/99

July 12, 1999 4:30 - 7:30 PM

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25 Van Ness Ave., Room 330-A

(Please note the location of this meeting is not City Hall)

Agenda

I.	Call to Order	4:30 PM
II.	Roll Call	4:32 PM
III.	Review and Approval of Agenda	4:35 PM
IV.	Review and Approval of Minutes from 5/26/99 - VOTE	4:40 PM
V.	General Announcements	4:45 PM
VI.	Public Comment	4:50 PM
VII.	Mayor's Liaison Report – Bill Barnes	5:00 PM
IX.	Membership Committee	5:05 PM
	• Nomination of incumbent members for additional term - VOTE	
	• Update	
X.	Department of Public Health Report	5:15 PM
	• Barbara Garcia, Deputy Director	
	• Monique Zmuda, Chief Financial Officer	
	Break	5:45 PM
XII.	Needs Assessment Presentation - Part II	6:00 PM
XIII.	New Business	7:25 PM
XIV.	Adjourn	7:30 PM

SF Dept. of Public Health — AIDS Office, 25 Van Ness, 5th floor
City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

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I. **Call to Order**
4:30 PM

II. **Roll Call**
Attachment A, Column 1

III. **Review and Approval of Agenda**
Under agenda item VIII, Membership Committee, the nomination of incumbents was moved to the next council meeting.

IV. **Review and Approval of Minutes**
There were no minutes presented.

V. **General Announcements**

- *LCG* announced a discussion on welfare reform and immigrants scheduled for August 3. She suggested council members ask her for details.
- *TL* read a statement to the council on Prioritization for FY 2000 based on his experiences [Attachment B]. He submitted a motion **"to direct the AIDS Office to remove 80% of the funding for case management and for peer advocacy from all agency contracts and that this money be put into a single agency RFP requiring that all agencies coordinate through this system."**
- *DJ* announced: (1) A prioritization workgroup on Monday, July 19, 4-8 PM, 25 Van Ness Ave., Room 330-A. (2) The next council meeting on Monday, July 26, 4:30 - 7:30 PM, City Hall, Room 201, that will include presentations from Marin and San Mateo counties. (3) Two council meetings in August, Monday, 8/9 and Monday, 8/23.

VI. **Public Comment**

- *Gene London* distributed a letter requesting the council to direct the AIDS Office to contract for updating and printing the HIV resource guide on an annual basis. [Attachment C]
- *Michael Petrelis* (1) urged the council to submit *TL*'s statement to gay newspapers; (2) asked why council co-chairs were not involved in Senate hearings on CARE Act funding re-appropriation held in San Francisco last week; (3) said there were no figures released on sexually transmitted diseases for last year and wondered how the council could prioritize without them; (4) attended a public meeting at Project Open Hand where funding cuts were discussed and asked that salary cuts be included in that discussion.

VII. **Mayor's Liaison Report**
Bill Barnes distributed Mayor Brown's testimony to the United States Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education and related agencies, [Attachment D] and a report to the council. [Attachment E]

VIII. **Membership Committee Report**

- The vote on nomination of incumbent members for additional terms was tabled to the next council meeting.

- Update
LG distributed (1) a letter, dated 7/2/99, to Steve Kawa regarding members terms; (2) a chart of current status of term membership; (3) a letter, dated 7/7/99, to Mayor Brown submitting Sister MaryMae Himm and Jim Mitulski as nominees for appointment; (4) two e-mail messages to Steve Kawa regarding members' terms. [Attachment F] She emphasized the need for the Mayor to appoint members to the council. She asked *Michael Moors* to contact members whose terms were about to expire to determine if they would reapply for membership to the council. *MS* suggested council members call the mayor directly and urge him to make appointments to the council. *DJ* asked members of the Dept. of Public Health (DPH) to add their voice to that of the council in requesting the mayor to make appointments. *TC* pointed out that there was a problem last year during prioritization due to lack of representation of the Latino community on the council. He said the council still does not accurately reflect the populations most affected by HIV and that the DPH budget

does not reflect their needs. *LDLT* asked what would happen in the grant application process if the council does not have complete representation of the communities it serves. He was also concerned there has not been an orientation for new members since he has been on the council.

IX. **Department of Public Health Report**

- *Barbara Garcia*, Deputy Director, DPH, noted that healthy tension between government and community is inevitable. She said coordination issues are being discussed between various councils. She pointed out the CARE Council works ahead of most other councils since they plan for the upcoming year. She felt the information the council gathers should be shared with other councils so that everyone is working from the same master plan. She said priorities are not currently being set by the DPH, which needs to happen, and that the DPH will use the council's recommendations in setting those priorities. She was committed to ensuring that the DPH manages organizations rather than programs.

- *Monique Zmuda*, Chief Financial Officer, DPH, distributed an overview of the department's budget. [Attachment G] Figures are for FY 99-00. The Board of Supervisors will be voting on the budget during their next two sessions.
  1. Sources of Revenue - Medi-Cal accounts for the largest source of revenue (31%).
  2. Expenditures - Salaries & Fringe Benefits are the largest source of expenditures (48%).
  3. Highlights of budget enhancements - $25 million from the city's General Fund went to replace lost federal and state dollars to SFGH/LHH.
  4. Board of Supervisors Add Backs to budget - $1,851,000
  5. Expenditure by Program - divided into Public Health and Community Health Network.
  6. Future trends in health care - continued risk of Federal & State reductions to reimbursement most critical. The number of uninsured people in SF is about 170,000 and will continue to increase.
  7. DPH responses to funding challenges - increase community alternatives to institutional care. HIV care has been a model in this area.

Discussion: *MS* asked what the DPH budget was last year. *Monique* said it was $824 million. *DJ* asked what was being done about salary savings. *Monique* explained that salary savings are funds not meant to be spent and that the requirement is 8% of the salary budget. She said the natural rate of attrition is around 5%. The DPH is allowed to pick which jobs they want to fill since there isn't enough money in the budget to fill all vacant positions. She said the salary saving situation is better this year than last. *TC* pointed out there is no fast track for CARE funded grant positions. *DJ* asked where the DPH is headed overall. *Barbara* said labor negotiations is a big issue, as well as reducing reliance on institutions for addiction and substance use treatment, African American health issues, and integrating the needs of clients. *LG* asked about increasing Medi-Cal and Medi-Care revenues. *Monique* said that eligibility workers in the DPH try to work more dollars out of Medi-Cal and Medi-Care. She said many people no longer qualify because they're single males. *LO'C* noted that it's difficult to coordinate with other councils. *Barbara* said the DPH realizes it's going to take some work and time to bring the various councils together. She said the CARE Council works about a year ahead of most other councils in terms of funding. The DPH is planning a large meeting of all the councils to update everyone. Their staff is reviewing the recommendations of all the councils. She said harm reduction and cultural competency are issues the DPH will include as they move forward. *NN* asked for a description of the department's strategic planning process. *Barbara* said they are working on a prioritization process for the next two years and would report back to the council when it's complete. *MJW* asked where tobacco settlement money went within the department and what the annual amount was. *Monique* said all those funds would go to the rebuilding of Laguna Honda Hospital with the exception of $1 million, which would go to tobacco use prevention. The amount is between $16-19 million annually. *TC* said the challenge for the DPH is how to implement the priorities of this council. Secondly, the potential reduction in CARE dollars needs to be thoughtfully planned. He felt it was important under those circumstances that the council, DPH, and the Mayor's Officer were not battling each other. *Barbara* agreed and said she wanted to start setting the groundwork for the eventuality of less funding now. *TC* asked for a commitment from the department to urge the mayor to appoint new members to the council. *Barbara* said she would speak to Mitch Katz, Director, DPH.

X. **Needs Assessment Presentation - Part 2**

Gary Levinson, Director, HIV Special Projects, Support Center for Nonprofit Management, reviewed (1) the study of Medical Providers at CARE-funded Agencies in San Francisco, and (2) a Focus Group Study of Client Experiences with HIV Health Services in San Francisco and San Mateo Counties.

Medical Providers Study

Strengths of San Francisco's CARE Program include:

- Strengths of CARE program and provider agencies
- Expertise and commitment of medical providers
- Strong community base of CARE program

Models of Service Delivery include:

- Integrated services
- Centralized services
- Institutions of excellence
- Neighborhood based care

Weaknesses of San Francisco's CARE Program include:

- Providing stable housing, mental health services, and addiction treatment
- Underserved populations
- Gaps and barriers

Treatment issues identified were:

Adherence to medications and treatment plans.
Need for better medication technologies.
Long-term management.
HIV is a low priority for some clients.
Keeping appointments and communicating with medical providers between appointments is challenging for some clients.
Need to protect women's reproductive rights and respect their choices.
Need to "negotiate" with clients about their requests for anti-anxiety medication.

Service delivery issues identified were:

Pharmacy access.
Specialty services access.
Insufficient funding for complementary therapy.

CARE program issues identified were:

Communication within the community: Planning Council, AIDS Office, and provider agencies.
Excessive and inappropriate documentation and reporting requirements.

Social issues identified were:

Poverty.
San Francisco's housing crisis.
Service needs of people who are HIV+.
Need for public policy reform.
Homophobia.

Discussion: *DJ* noted that the perception of the providers and clients of mental health services are mismatched. *Michael DeMayo* said that the quantitative data showed clients of mental health services did not always perceive that as a need while their providers did. *MJW* asked what number of study participants identified mental health as an area of concern. *Gary* said that 50% did. *MS* asked what was meant by better medication technologies. *Gary* said that twice daily dosing was an example. *LDLT* asked how the study sample was selected. *KB* said it was an internal process of finding CARE funded providers. *SO* asked why providers support integrated services. *Gary* said many multi-diagnosed people need a family structure approach to care. Clients feel more taken care of when they get multiple services at one site. *MJW* asked how many of the participants represented alternative therapy. *Gary* said there were three. *KB* asked if providers mentioned home health needs. *Gary* said they had not. *LG* asked if any participants mentioned racism. *Gary* said none had.

Conclusions of study: Very few unmet needs other than housing.

Focus Group Study of Client Experiences with HIV Health Services in San Francisco and San Mateo Counties.

Seven requirements for a client-centered system of care:

1. To be treated with compassion and respect

2. Reliable, easily accessed information about treatment and service options
3. Streamlined, equitable access to a comprehensive system of care
4. Help with needs that are not specifically HIV-related
5. Reward client health by giving clients an improved quality of life
6. Connection to a community of other people living with HIV/AIDS
7. The opportunity to contribute and give something back to the community

Gary noted that the focus groups show that people feel more isolated than ever before.

Discussion: The council determined that the wording of #5 should be changed. *Gary* agreed.

Conclusion: Three recommendations for future action.

1. Investigate the issue of quality of care.
   - Examine the current data in more depth
   - Commission an independent study of client satisfaction
   - Commission an independent study of providers
   - Study service utilization patterns
   - Develop ways to track and updated resource availability
2. Explore the best ways to serve the unstable client.
3. Coordinate planning with other service sectors: Mental Health, Substance Use, and Housing.

Discussion: *LG* asked if there were any recommendations on specific populations. *Gary* responded that these were broad-based recommendations that included information to help the council decide where funds should be directed. *DJ* wondered how the council can investigate quality of care with no money budgeted for that purpose. *Michael* said there is much data that can be analyzed over the next few years. *Laura Thomas* said the council owns the data since they paid for the assessment. The AIDS Office is trying to find dollars to do deeper analysis of data. *DJ* said she was trying to understand the discrepancy between the level of service *TL* described earlier in the meeting and what clients of the needs assessment are saying. *TL* thought self-reporting from consumers may reflect their fear of losing services; they may have lowered expectations based on what services they have access to. He suggested the low number of unmet needs might be a consequence of clients thinking that within the confines of what they have access to their needs are being met. *Gary* said that fell into a category of unsatisfied need. People often get their needs met in an unsatisfactory way. *LG* said this dynamic shows up frequently in homeless populations. *Michael* suggested a client satisfaction survey be done.

1999 Client Needs Assessment. *Gary & Michael* distributed and discussed the organization of the assessment. *Michael* stated the client survey data is in the second section of the assessment. The methods of sampling are described starting on page 5; a detailed description of service categories starts on page 27; special populations including homeless, multiple diagnosed, and women are included in the survey starting on page 45. He noted that there was a high unmet need in four areas: housing, dental, transportation, and home health care. *LO'C* asked in there was any analysis of transgenders since they seemed to have high unmet need in many categories. *Michael* said they did not do separate analysis on trangenders but that the data did support a high unmet need in that population. He said that housing and dental arose as the top two unmet needs across all criteria the survey measured by.

XI. **New Business**

TL asked that his motion under General Announcements be submitted for the next meeting.

XII. **Adjournment**

7:45 PM

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HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

7/12/99		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	*KB*	P											
Dorothy Bartolomucci	*DB*	A											
Donald Bliss	*DCB*	P											
Jeff Byers	*JB*	P											
Virginia Cafaro	*VC*	A											
Tom Calvanese	*TC*	P											
Bart Casimir	*BC*	A											
Veronika Cauley	*VC*	A											
Julie Charubusapayon	*JAC*	P											
John Conley	*JC*	P											
Luis De La Torre	*LDT*	P											
Mark Dunlop	*MD*	P											
Gene Gowdey	*GG*	A											
Laura Guzmán	*LCG*	P											
Siddiq Jihad	*SJ*	A											
Darrell Joe	*DCJ*	A											
Diane Jones	*DJ*	P											
Samuel Kaplan	*SK*	A											
Tony Leone	*TL*	P											
Allen Meyer	*AM*	A											
Lee Ann Monfredini	*LM*	A											
Norm Nickens	*NN*	P											
Lisa O'Connor	*LO'C*	P											
Loras Ojeda	*LO*	A											
Jorge Ortiz	*JO*	P											
Stephan Oxendine	*SO*	P											
Alissa Riker	*AR*	P											
Nilda Rodriguez	*NR*	P											
Matthew Sharp	*MS*	P											
Susan Shea	*SS*	P											
Kelly Wallace	*KW*	P											
Eric Whitney	*EW*	P											
Mary Jane Wood	*MJW*	P											

ATTACHMENT B.

Statement to the San Francisco HIV Health Services Planning Council for Prioritization for FY 2000

Presented by Tony Leone
July 12, 1999

This is my third Prioritization process. I have been a member of this

Council for two years. In that time I have listened to and about :

MSM,

MSF,

MSM/F

Women who have sex with women,

Women who have sex with men,

Women who have sex with men & women,

FTM Transgenders,

MTF Transgenders,

Youth,

Latinos,

African-Americans,

Homeless,

Street walkers,

Street sleepers,

Street workers,

Sex workers,

Pot growers,

Pot smokers,

Peer Advocates,

Legal Advocates,

Professional Advocates,

Nurse Aides,

Registered Nurses,

Nurse Practitioners,

Social Workers,

Psychologists,

Medical Doctors,

Psychiatrists,

Bureaucrats,

Politicians,

Public Health Officials, and

Case Managers.

There is one group glaringly absent from this list. Listen closely, the sound of their voices are deafening. Yet I've never seen us have a panel of just

gay men at this Council. Currently, gay men compose 82% of all diagnosed AIDS cases. That's 20,482 out of 25067 people. These are People Like ME (PLM's). If you add gay men who are also IDU's they amount to 93% of the diagnosed AIDS cases in San Francisco.

I keep hearing how the face of AIDS has changed. Frankly, I'm tired of hearing how the "face of AIDS has changed". In fact deaths from AIDS has declined by about 50% annually. Now we seem to want to look only at those 50% who are doing well. The ones for whom HAART is working, those who are re-entering the job market and in essence getting their lives back. I don't think we've recently looked at the other face of AIDS, the 50% who are still in pain and dying. The ones for whom drug cocktails are not working. The system is responding very poorly to the needs of the truly sick.

First, let me say I don't represent anyone but myself. But you may detect commonalties in my story. I want to share with you what I have been through over the last 6 months. I think it's very important as we go into prioritization. Given my health, I may not be here for another Prioritization.

The past 2 years saw the input from PWA's ignored and brushed aside by this Council during the Prioritization process.

Over the past 4 years I have lost 200 pounds. This was not by choice or design. I have had to live with chronic diarrhea nad vomiting.

Beginning at the end of January of this year I began to again loose weight uncontrollably. Worse, I developed near constant abdominal pain. I went to the Urgent Care Center at SFGH for a prescription for Tincture of Opium to help control the diarrhea. Upon arrival I had the urgent need to use a bathroom. The nurse refused to tell me where the bathroom was because she said they might need a specimen and I should wait. Of course I was incontinent (ie I shit my diaper). Whem I asked for a clean diaper so I could ride the bus home without sitting in shit, I was told they don't have anything and could not help me. I was I was given a folded up piece of blue plastic. I had no way to secure it in place. Before I could even get out the Hospital door, it had slipped and slid down my right leg. I was painted with stool from my anus to my ankle. I just can't understand why this was necessary.

As I continued to lose weiht at the rate of about 15 pounds a month, I could get no one including my Doctor to listen yo my complaints of pain, anorexia and vomiting. Finally, in May as I was near collapse a friend helped me to the Hospital. My Potassium level was critical and I was very dehydrated and significantly anemic requiring blood transfusions. The abdominal pain throughout this whole period was always present. When I asked that a CMV Serolgy test be done so I would know if I should request CMV negative Blood, I was refused. They said that since I was Gay they wouldn't do it. Since most Gay men are positive they refused to do the blood test on me.

I got home from the Hospital and waiting in the mail for me was the most insulting letter I could imagine from Project Open Hand. They want me to prove need every 6 months and prove I still have AIDS. Until there is a cure for AIDS I will always have it. I will die with it if not from it. I'm exhausted and in so much pain I can't stand it. If anyone needs food and grocery support it is me. Putting any further burden for paperwork and proving that I still have AIDS is unconscionable. I'm just so sick of being in pain. For the first time in my life I truly understand why some people self-euthanize.

Also waiting at home was three months of dirty laundry. My living room floor was covered with stool and vomit covered dirty clothes. The sink full of dirty dishes not only smelled but was literally rotting. **I had 4 case managers and no one could help me get my laundry and dishes done.** The Derek Silva Case Manager was only concerned about getting my rent paid. They were all very concerned about filling their units of service. One case manager spent 40 minutes out of the hour she spent with me telling me how she met her lover and what it takes to maintain a successful lesbian love relationship. I doubt this information will ever be of use to me. I sat there in pain during this whole episode. Again, no one could help me get my laundry done. Another case manager sat with her nose out my window looking at the mess of dirty laundry and saying "I wish there was something I could do."

The dehydration caused my corneas to dry out almost completely and my vision was severely impaired. The Eye Doctors said there was nothing to do but put ointment in them and wait for the corneas to become re-moisturized. Shortly after I was released from the Hospital I managed to go to Safeway to get groceries. I stood in the store crying because I could not read the labels on the food. Four case managers and ,no one could help me get groceries.

No one seemed to be able to help with the real needs: laundry, groceries, and dishes. The system is failing PLM's. Case management is a boondoggle.

I am submitting a motion to direct the AIDS Office to remove 80% of the funding for case management and for peer advocacy from all agency contracts and that this money be put into a single agency RFP requiring that all agencies coordinate through this system.

Thank you for your time and attention.

ATTACHMENT C

June 30, 1999

To: CARE Council

Re: HIV Resource Guide

It can be difficult for both clients and providers to navigate the vast arena of HIV/AIDS services available in San Francisco. Inadequate and/or incorrect information from providers has been identified as a significant barrier to access to services, in the current Client Needs Assessment Survey.

I have found that one of the most useful tools for identifying and accessing services is the HIV Resource Guide 1997-1998, published and distributed by the San Francisco AIDS Foundation. I and my colleagues have used the guidebook extensively, both in my previous work as clinical director of the Immune Enhancement Project and in my current position as director of The HIV Program at the American College of Traditional Chinese Medicine.

The guidebook is an important and highly utilized resource, and I was surprised and disappointed to learn that a decision was made to eliminate it, without (as far as I know) any community input.

While an online guide is also useful (especially for keeping up with changes in a timely manner), it is not a satisfactory substitute for the HIV Resource Guide in book form. (The currently available 2-year-old edition is less useful than a revised edition would be, but far more useful than no edition at all.)

I first learned of this decision from a letter by Bob Lehr, MSW, printed in the *Bay Area Reporter*, May 13, 1999. (It was confirmed in a phone call to the SFAF Client Services department two weeks ago.) With his permission, I've attached a copy of Mr. Lehr's letter. (I am not aware of a response from the SFAF.)

I request that the CARE Council advise the AIDS Office to contract for the updating and printing of the HIV Resource Guide for 1999-2000, and for future annual or biannual revisions.

Thank you for your consideration.

Sincerely,

Gene London, L.Ac.
415-282-7600 x25

May 6, 1999

Letter to the Editor:

I have learned that the San Francisco AIDS Foundation (SFAF) does not plan to print an updated version of its HIV Resource Guide. The reason given to me over the phone by an employee in the Client Services Department was that there were too many changes for them to keep it appropriately updated. Rather, the Guide is now on-line through the SF Public Library. As I later learned when I tried to use it, getting information from it quickly is not easy; it is not a very user-friendly system. The decision not to reprint is regrettable.

I am an HIV social worker at San Francisco General Hospital's outpatient HIV clinic, and I have always found the Guide a useful resource that is quick and easy to use. However, because the new on-line system is not in a book format nor is there any table of contents or index), it is not even useful to print it out as an office reference. I find more and more patients asking me what services the SFAF offers these days; now that they have eliminated the printed Guide, the list of those services shortens once again.

I am sending a copy of this letter to the SFAF so they will have my reasons for regretting their decision. These include:
- Poor and homeless HIV-positive people need to have ready knowledge of the services available; my guess is their access to the Internet is limited.
- People who are newly diagnosed or newly arrived in San Francisco are going to want to be able to learn quickly what services are available; I would prefer to be able to provide them with a printed guide.
- I haven't found it inconvenient in the past to write in the old Guide any new addresses or phone numbers for agencies as I discover them; I wonder how frequently the database will be updated.
- For me time is precious, and booting up a computer to search through a layered database (even assuming one has on-line access) is far clumsier than thumbing through a book.

I now urge service providers and their clients/patients to write/ call the AIDS Foundation and express your reason(s) why you think an updated print version of the Guide is needed.

Bob Lehr

ATTACHMENT D

OFFICE OF THE MAYOR
SAN FRANCISCO

WILLIE LEWIS BROWN, JR.

UNITED STATES SENATE
COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION
AND RELATED AGENCIES

TESTIMONY BY
WILLIE LEWIS BROWN, JR.
MAYOR OF THE CITY AND COUNTY OF SAN FRANCISCO

JULY 9, 1999

ONE DR. CARLTON B. GOODLETT PLACE, ROOM 200, SAN FRANCISCO, CALIFORNIA 94102
(415) 554-6141

Good afternoon, Chairman Specter and members of the Committee. My name is Willie Lewis Brown, Jr., and in 1995 the voters of the City and County of San Francisco elected me their Mayor. Prior to that, I served for 15 years as Speaker of the California State Assembly. I come before you today to request the Committee's support for vital increases in Fiscal Year (FY) 2000 funding for federal HIV/AIDS-related programs administered by the U.S. Departments of Health and Human Services and Labor, and to address the role of federal-state-local partnerships in addressing the AIDS crisis.

San Francisco has long been a leader in the fight against AIDS. We have provided local support for our community-based response since the first desperate days prior to Federal funding, when health departments in major cities were staggering under the weight of increasing caseloads of young, terminally ill individuals presenting at hospital emergency rooms with obscure and deadly ailments. The City and County has provided significant leadership and financial resources to combat this epidemic since 1981 and we remain committed to doing so.

In 1983, as a member of the California Assembly representing San Francisco, I secured the first state funding in the nation for AIDS programs – a $3 million appropriation that set the stage for the federal and state support we are talking about today. In that time, the fear surrounding this illness served as the major obstacle to securing these desperately needed funds. Today, this fear has been replaced with a premature sense of victory and an unacceptable level of complacency.

Last October, the Centers for Disease Control and Prevention (CDC) reported a 47% decline in AIDS-related deaths between 1996 and 1997, and a corresponding 12% increase in the number of people living with AIDS. During this same time period, new HIV infections have remained steady at about 40,000 per year. **As a result, local communities such as San Francisco will continue to experience steadily increasing demand for HIV-related medical and supportive services.** Not only are more persons living with HIV disease, but their needs are much more complex and the cost of care continues to escalate unabated.

The Federal response to AIDS has literally prevented the collapse of local public health systems, and has enabled hundreds of thousands of low-income, uninsured individuals living with HIV/AIDS to receive high-quality health care and supportive services. These Federal resources have also helped to leverage millions of dollars in state, local and private funding for HIV/AIDS programs.

I fully and strongly support the FY 2000 HIV/AIDS appropriations recommendations of the National Organizations Responding to AIDS (NORA). In my testimony today, I would like to highlight several programs and initiatives that play a particularly important role in the City and County of San Francisco's response to this epidemic, and discuss our partnership with the Federal government to bring an end to this crisis.

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Programs

I strongly support the community request that the Committee provides $625.2 million overall, or a $120 million increase for Title I of the Ryan White CARE Act in FY 2000. This funding for Title I is required to maintain access to medical care, treatment and supportive services for those individuals already in care, and to ensure access to care for those who will enter care for the first time.

In response to recent HIV treatment advances, the number of individuals seeking medical care and treatment, as well as the cost of care, has grown markedly in recent years. A 1998 study by the Cities Advocating Emergency AIDS Relief (CAEAR) Coalition reported an average increase of 43.5 percent in the number of new HIV/AIDS clients entering CARE-funded systems between 1995 and 1997. In FY 2000, the number of new clients seeking care is expected to increase by 20 percent. This study also demonstrated that the overall cost of care grew substantially during the same time period. This increase in the cost of care is related to three factors: 1.) increases in the number, length and complexity of medical visits (65 percent increase in length of each visit and a 27 percent increase in the number of visits); 2.) new and expensive

diagnostic tests, and; 3.) the use of lifesaving pharmaceuticals not covered by the state-based AIDS Drug Assistance Programs (ADAP).

The fifty-one Eligible Metropolitan Areas (EMAs) funded through Title I of the CARE Act are home to 74 percent of all reported AIDS cases in the United States. Together, an estimated 156,000 people with HIV/AIDS will be served in these epicenters in FY 2000.

Because more communities are becoming hard hit by AIDS despite our best efforts, in FY 2000, up to three new communities may become eligible for Title I funding. These emerging epicenters must be funded adequately, and not at the expense of existing Title I areas that are also continuing to experience growing service needs. Because of inadequate appropriations in FY 1999, seven Title I areas actually received less funding than in FY 1998, including the Californian communities of San Francisco/San Mateo/Marin and Santa Rosa/Petaluma. At a time when the nation continues to see approximately 40,000 new HIV infections annually, with many individuals thankfully living longer due to treatment advances, funding cuts run counter to common sense and good public health practice.

As the second decade of the epidemic comes to a close, it is clear that the HIV/AIDS epidemic is far from over. It is also apparent that HIV medical care and treatment will continue to be complex, expensive (albeit less expensive than inpatient hospital-based care), and unavailable or unworkable for some. Despite the promise of new drugs, there continues to be a significant number of individuals who cannot tolerate side effects, or whose bodies have become resistant to them rendering the medications ineffective. These individuals, as well as those struggling to continue their treatment, will need essential support services.

According to the Health Resources and Services Administration (HRSA), approximately 64 percent of Title I clients nationally are people of color. Despite aggressive outreach to disenfranchised communities, medical care and anti-HIV treatment utilization by communities of color continue to lag. These continued disparities translate into poorer

health outcomes, including slower reductions in AIDS-related deaths. For this reason, in addition to the request for an overall increase in support for Title I programs, I support requests that the Committee increase funding for the Title I-specific appropriation that was approved as part of the FY 1999 Congressional Black Caucus HIV/AIDS Initiative. A significant increase in this targeted funding would allow Title I communities to protect and expand targeted programs in the African American community and other communities of color that are disproportionately affected by HIV/AIDS.

The AIDS Drug Assistance Program (ADAP)

I strongly support the request that the Committee provides $544 million overall, or an $83 million increase for the AIDS Drug Assistance Program (ADAP) in FY 2000. This funding level is necessary to provide ongoing services to the 53,765 clients who utilized state ADAPs in June of 1998 and to extend access to the estimated 500-600 new clients that will enter the program monthly in FY 2000. The National ADAP Monitoring Project reports that, compared to July 1997, in June 1998, ADAP programs served 22 percent more clients and the cost of treatment had grown by 37 percent due to increases in the cost per client, the number of clients served, and the increasing costs of combination anti-HIV drug therapies. ADAP spending for anti-HIV drugs grew by 54 percent between July 1997 and June 1998. Today anti-HIV drug costs represent 88 percent of ADAP expenditures.

I want to thank the Committee for its considerable support of ADAP in recent years. Since 1996, Congress has responded to the critical pharmaceutical needs of people living with HIV disease through significant increases in funding. Yet, despite these efforts, many states continue to face shortfalls and must restrict the number of drugs covered because of insufficient resources.

In California, Federal support for AIDS-related drugs last year leveraged an additional $51.6 million in state funding in FY 1998, allowing adequate access to ADAP for all

eligible Californians living with HIV/AIDS. The California ADAP formulary provides access to all 14 anti-HIV medications approved by the Food and Drug Administration (FDA). In addition, California's ADAP also includes over 80 FDA approved drugs that are used to treat opportunistic infections and symptoms associated with HIV disease. From 1997 to 1998, the national expenditures on drugs to treat opportunistic infections and other conditions actually decreased by 31 percent—a further indicator of the success of early care, treatment and support services.

The anti-HIV medications used in combination to create Highly Active Antiretroviral Therapy (HAART), while not a cure, will continue to offer opportunities for improved health to many individuals living with HIV/AIDS. Additional resources would also improve access to AIDS-related medications for African Americans and women living with HIV/AIDS who continue to have lower utilization rates. For all of these important reasons, I urge Committee support for this request.

HIV/AIDS Initiatives for Communities of Color

I request that the Committee provide a minimum of $250 million for targeted emergency assistance to address the severe and ongoing health crisis related to HIV/AIDS in the African American community and other communities of color. I want to thank members of the Committee, as well as members of the Congressional Black Caucus, for approving targeted resources in FY 1999 to respond to this growing health emergency. These successful efforts establish a foundation to increase financial support and technical assistance to respond to the AIDS crisis in African American, Hispanic/Latino, Asian and Pacific Islander, and Native American communities. My hope is that the impact of these targeted efforts will become evident in all HHS agencies that provide HIV services.

The majority of people living with HIV/AIDS in the U.S. are people of color. Communities of color often face additional health care and social service challenges. Therefore, targeted initiatives, which focus resources on emerging crises, may provide the most

strategic Federal response to address these intractable and longstanding problems. The CARE Act continues to provide an effective response to the fragmentation that exists in the U.S. health care system overall. Although the CARE Act cannot and should not be expected to eliminate longstanding health disparities that exist between groups, CARE Act grantees, providers and clients can and should act as agents for change. Targeted funding will help them do so. As Mayor of San Francisco, I am fully committed to working with Congress and the Administration to reduce racial disparities and improve access to quality care for all individuals living with HIV/AIDS.

HIV Prevention, Surveillance and Behavioral Research Programs at the Centers for Disease Control and Prevention (CDC)

I request that the Committee provide $848 million in total funding for HIV prevention, surveillance, and behavioral research at the CDC. This $191 million increase over FY 1999 levels would provide increased resources to reduce the 40,000 new HIV infections that occur annually in the U.S. Over 85 percent of the HIV prevention funds are allocated to state and local health departments, national and regional minority organizations and community-based organizations to provide both primary and secondary HIV prevention services.

HIV surveillance is an important component of effectively responding to the changing AIDS epidemic. Many states have taken the CDC's direction to implement HIV reporting to heart, and are developing systems that meet the needs of their communities. In California, Assembly Bill 103 (Migden) would create a non-names based system of HIV reporting, which I strongly support. Additional resources are necessary to ensure that these reporting systems are established in a timely manner. An increased appropriation for HIV surveillance should allow and promote flexibility in implementing systems that will be most successful in their respective states, and must allow the option of names or non-names based reporting.

Substance Abuse and Mental Health Services Administration (SAMHSA)

According to CDC, the majority of new HIV infections in the U.S. are now directly or indirectly related to drug use. Of those diagnosed with AIDS to date, drug use is linked to more than 30 percent of adult cases, 60 percent of cases among women and 53 percent of pediatric cases. **I support strongly community requests that the Committee provide $255 million to the Center for Substance Abuse Treatment (CSAT) and $255 million for the Center for Substance Abuse Prevention (CSAP).**

In closing, I also want to urge the Committee to support increased funding for HIV/AIDS research at the National Institutes of Health, as well as $1.7 million in funding for the Office of HIV/AIDS Policy (OHAP) at HHS. OHAP will continue to play a key role in the development of policies and priorities regarding HIV/AIDS, including the ongoing review of Clinical Guidelines on the Management of HIV Infection.

Thank you for this opportunity to testify before the Committee. I know that you share my commitment to ending this epidemic, and will work with diligence and integrity to see this worthy goal through.

ATTACHMENT E

OFFICE OF THE MAYOR
SAN FRANCISCO

WILLIE LEWIS BROWN, JR.

REPORT TO THE SAN FRANCISCO HIV HEALTH SERVICES PLANNING COUNCIL

Bill Barnes, Advisor to the Mayor on AIDS and HIV Policy
July 12, 1999

US SENATE HEARING ON HIV/AIDS APPROPRIATIONS
JULY 9, 1999, CITY HALL

The US Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies held a field hearing on Fiscal Year (FY) 2000 appropriations. Senator Arlen Specter (R-PA) chaired the hearing, and was joined by Senators Barbara Boxer (D-CA), Dianne Feinstein (D-CA) and Tom Harkin (D-IA).

Due to the Balanced Budget Act, appropriators are facing discretionary budget caps that jeopardize federal funding for various health related programs. National advocacy groups, members of Congress, and Mayor Brown have called on the congressional leadership to raise these arbitrary caps. AIDS Action Council has also called on appropriators to not participate in mark-ups (that is, the first step in the appropriations process) until the caps are revised.

According to the White House Office of Management and Budget, programs funded under the Ryan White CARE Act could suffer a $250 million reduction – compared to a $100 million Clinton administration increase or a more significant increase based on community needs.

Witnesses included Mayor Brown, former Congressman Ron Dellums (D-CA), Dr. Anthony Fauci of the National Institutes of Health, Dr. Paul Volberding of San Francisco General Hospital, Miss America 1998 Kate Shindle, San Francisco AIDS Foundation Board Member Lonnie Payne, Health Initiatives for Youth staff member Sean Sasser and Jeanne White of the Ryan White Foundation.

Mayor Brown's remarks are attached.

MUNICIPAL BUDGET UPDATE

The Fiscal Year (FY) 99-00 municipal budget will be approved by the San Francisco Board of Supervisors on July 19, 1999. The municipal budget reflects all local revenues and expenses, including those revenues from federal grants such as Ryan White Title I.

The Mayor's budget included a number of continuations and augmentations for AIDS programs.

Mayor Brown restored mental health programs de-prioritized by the Planning Council, adding $490,000 to the budget. With matching funds from Medi-Cal, no disruption in services is expected, and we project that services will be provided at the $850,000 level in FY99-00.

The FY 99-00 budget also includes an increase of $109,400 for Action Point Centers and an increase of $102,785 for HIV Medical Interventions for Substance Users. **In sum, the Mayor's budget contained $1,182,185 in new increases.**

The Mayor's budget also continued one-time funding in the 98-99 budget, including:
$170,000 for Latino HIV prevention programs;
an annualized $120,000 for Latino case management programs; and
$65,000 for the Shanti Project.

Once the Mayor's budget was sent to the Board of Supervisors, additional resources were committed to AIDS programs. In the Board's Finance and Labor Committee meeting of June 24, 1999, the following funds were added:

$21,000 for rent for the NAMES Project to retain its Castro Street location;
$75,000 for Shanti's Circle of Care Collaborative;
$75,000 for mental health services provided at New Leaf: Services for Our Community;
$350,000 for school-based health clinics; and
$67,000 for a benefits counselor and expanded evaluation of the Bridge Project.

All of these budget items are tentative until approved by the full Board on July 19, 1999. I will report any changes or additions to the Planning Council at its next meeting.

STATE BUDGET UPDATE

Governor Davis signed the state budget recently, taking his blue pen to a number of AIDS programs, including $1 million for partner counseling and referral, and $1.6 million for HIV testing at family planning clinics. Earlier in the session, the Governor was criticized for decreasing the state contribution to the AIDS Drug Assistance Program and diverting the state savings away from AIDS programs. In sum, the California budget includes $13.4 million in increases for AIDS compared to last year's budget. These increases include:

$1.825 million for early intervention programs (EIPs);
$1.0 million for Residential Care Facilities for the Chronically Ill (RCFCIs);
$6.0 million for prevention education ($3.0 million targeted at communities of color and women and $3.0 million for high risk men who have sex with men and high risk youth);
$2.0M for prevention evaluation/behavioral surveillance; and
$2.6 million for HIV/AIDS prevention and care services for communities of color.

In addition, $1 million was provided for research on organ transplants for persons with HIV and AIDS, and $2 million for the Universitywide AIDS Research Program. These increases come as a direct result from advocacy from the California HIV Advocacy Coalition.

Council Appointments

There is no new information on Planning Council appointments. Mayor Brown has received the letter from the Planning Council, and is considering the recommended candidates.

Additional Issues

Planning Council members and members of the public are invited to call Bill Barnes to discuss additional issues at (415) 554-5101.

ATTACHMENT F

July 2, 1999

Steve Kawa, Director of Legislative Affairs
Mayor's Office of Finance and Legislative Affairs
401 Van Ness, Room 304
San Francisco, CA 94102

Dear Steve:

I am writing to thank you very much for the opportunity to meet with you, Tom Calvanese and Bill Barnes at your office on June 23. I believe the session was very fruitful, and I am particularly happy that we were able to reach an agreement regarding the HIV Health Services Planning Council members' terms before our fiscal year 2000-2001 prioritization process ends.

Through this letter, I am seeking to memorialize our June 23 agreement. I would truly appreciate a very prompt response to this letter in writing.

At our June 23 meeting, the Mayor's Office and the HIV Health Services Planning Council (HSPC) reached consensus on the following items:

- The Mayor's Office agreed that beginning November of 1998, Council members should serve **2- year terms**, thereby honoring HSPC's by-laws change of November of 1998. In keeping with this, the Mayor's office is committed to appointing individuals having only served for one year to another term, should they seek appointment.
- The following members are currently serving **2-year terms**, beginning in March, 1999, and ending in March, 2001: John Conley, Samuel Kaplan, Laura Carcagno Guzman, and Luis De La Torre. Since this fact was not indicated in their appointment letters, it will need to be confirmed in writing.
- The Mayor's Office agreed to honor Council's date of **Appointment** for each Council member as reflected on the attached spreadsheet. This spreadsheet replaces the Attachment to Letter to Mayor Brown of June 7, 1999. Letters of appointment issued in March of 1999 (except for the above named individuals) are therefore **void.**
- The November 1998 by-laws change will be applied **prospectively** and not retroactively due to **potential policy implications.** Even though this decision may

impact some Council Members whose terms are close to expiring or have expired, the Mayor's Office is committed to accommodate those members expeditiously.

- For those members whose terms are close to expiring, or have expired (the shaded areas on the attached spreadsheet):
    - They will have the opportunity to apply for a **new 2-year term** **AND**
    - They will continue **to serve out their current term** until a determination has been made concerning their request for another term (until the Mayor appoints them).
- For those members appointed before November 1998, their terms end on the **last day of the month** in which they were originally appointed.

Sincerely Yours,

Laura Carcagno Guzmán, JD
Membership Chair,
SF HIV Health Services Planning Council

attachment

Membership Committee
HIV Health Services Planning Council
25 Van Ness Avenue, 5th Floor
San Francisco, CA 94102

July 7, 1999

Honorable Mayor Willie Brown Jr., Mayor
City and County of San Francisco
One Dr. Carlton B. Goodlet Place, Room 200
San Francisco, CA 94102

Dear Mayor Brown:

On Monday, June 28, 1999, the HIV Health Services Planning Council voted to endorse the Membership Committee's recommendation regarding new members. In accordance with our nomination process, I am now submitting the names of the following nominees for your review and appointment (applications are attached):

Sister MaryMae Himm is a 33-year old, HIV+ Caucasian, gay male who is a local community leader and activist. Sister MaryMae's community work includes his volunteer activities with the Sisters of Perpetual Indulgence and his membership on the HIV Prevention Planning Council (HPPC). Sister MaryMae chairs the HPPC's Strategic Evaluation Committee. After 15 years of HIV prevention work, Sister is very interested and committed to act as a bridge between the HPPC and our HIV Service Council.

Jim Mitulski is a 41 year-old, HIV+ Caucasian, gay male, who has worked for 14 years as a pastor for the Metropolitan Community Church (MCC) in the Castro district. In addition to his pastoral and social service through MCC, Jim has also been a member of the G/L/B/T Task Force of the San Francisco Human Rights Commission. He is committed to coalition building and to represent the faith community on the Council.

With the addition of **Sister MaryMae Himm** and **Jim Mitulski**, there are now a total **ten new members and five incumbents** awaiting appointments (please refer to my letter dated June 7, 1999). The names that have been already submitted to your attention are as follows:

> **New Members**: Al Terrazas, Raymond Combs, Gregory Edwards, Hazel Betsy, Alliena Baker, Mike Shriver, Ken Pearce, and Gene London. **Incumbents**: Kirsten Balano, Mark Dunlop, Gene Gowdey, Nilda Rodriguez, and Kelly Wallace.

We are **urging you** to help us address the potential implications of not having these members on board before the end of our prioritization for the fiscal year 2,000-2,001. Although we are already inviting them to come and attend our next Council

meetings, they cannot fully participate during the prioritization process unless they are **officially appointed** by no later than this coming Friday, July 10, 1999.

Thank you for your time and consideration related to these recommendations for appointments to the San Francisco HIV Health Services Planning Council. Please feel free to contact me at (415) 972-0808 should you have any questions regarding this recommendation.

Sincerely yours,

Laura Carcagno Guzmán, JD
Chair, Membership Committee

Attachments.

cc: Bill Barnes
Steve Kawa

	Representative	Category of Representation	Appointment	End of Term	Current Status (June, 1999)
1	Lisa O'Connor	Other Federal HIV Programs - SPNS	Mar-98	Mar-99	submit request in July
2	Dorothy Bartolomucci	Non-Elected Community Leader	Apr-98	Apr-99	submit request in July
3	Donald Bliss	Mental Health Provider	Apr-98	Apr-99	submit request in July
4	Allen Meyer	Title III	Apr-98	Apr-99	submit request in July
5	Loras Ojeda	CBOs Serving Affected Populations/ASOs	Apr-98	Apr-99	submit request in July
6	Steve Oxendine	CBOs Serving Affected Populations/ASOs	Apr-98	Apr-99	submit request in July
7	Lee Ann Monfredini	Health Care Planning Agency	May-98	May-99	submit request in July
8	Kirsten Balano	Other Federal HIV Programs: AETC	Jun-97	Jun-99	pending appointment
9	Mark Dunlop	Other Federal HIV Programs: HOPWA	Jun-97	Jun-99	pending appointment
10	Gene Gowdey	Other Federal HIV Programs - Dental	Jun-97	Jun-99	pending appointment
11	Nilda Rodriguez	Affected Communities	Jun-97	Jun-99	pending appointment
12	Kelly Wallace	CBOs Serving Affected Populations/ASOs	Jun-97	Jun-99	pending appointment
13	Norman Nickens	Local Public Health Agency	Jun-94	Jun-99	submit request in July
14	Veronika Gauley	Affected Communities	Jul-97	Jul-99	submit request in July
15	Tony Leone	Affected Communities	Jul-97	Jul-99	submit request in July
16	Matthew Sharp	Affected Communities	Jul-97	Jul-99	submit request in July
17	Uell Byars	State Title III Agency	Jul-96	Jul-99	submit request in July
18	Tom Calvanese	Affected Communities	Sep-95	Sep-99	submit request in August
19	Virginia Cafaro	Health Care Provider	Sep-96	Sep-99	submit request in August
20	Bartholomew T. Casimir	Social Service Provider	Sep-96	Sep-99	submit request in August
21	Diane Jones	Health Care Provider	Sep-96	Sep-99	submit request in August
22	Alissa Riker	Substance Abuse Provider	Sep-96	Sep-99	submit request in August
23	Chris Boehm	Title IV	Sep-98	Sep-99	submit request in August
24	Julie Charubusapayan	UCSF Women's and Children's program	Sep-98	Sep-99	submit request in August
25	Siddiq Jihad	Substance Abuse Provider	Sep-98	Sep-99	submit request in August
26	Jorge Ortiz	Affected Communities	Sep-98	Sep-99	submit request in August
27	Eric Whitney	Affected Communities	Sep-98	Sep-99	submit request in August
28	Susan Shea	Health Care Provider	Sep-98	Sep-99	submit request in August
29	Darrell Joe	Affected Communities	Oct-98	Oct-99	submit request in September
30	Mary Jane Wood	Mental Health Provider	Nov-90	Nov-99	submit request in October
31	John Conley	Local Public Health Agency	Mar-99	Mar-01	serving two-year term
32	Samuel Kaplan	State Medical Representative	Mar-99	Mar-01	serving two-year term
33	Laura Carcagno Guzman	Other Federal Programs - SPNS	Mar-99	Mar-01	serving two-year term
34	Luis De La Torre	Affected Communities	Mar-99	Mar-01	serving two-year term

NOTES: Shaded area indicates members needing to submit requests to Membership Committee in order to continue to serve.
Terms for members appointed before November, 1998 end on the last day of the month of "End of term"

Carcagno, Laura

From: Carcagno, Laura
Sent: Wednesday, July 07, 1999 12:15 PM
To: 'steve_kawa@ci.sf.ca.us'
Cc: 'Bill_Barnes@ci.sf.ca.us'
Subject: HIV Health Services Planning Council Members' Tems Agreement

Dear Steve:

I hope you have received by now an e-mail and fax copy reflecting our June 23 agreement on Members' Terms. I will n you a hard copy today. As you probably know, I am anxiously awaiting your response in writing so we can finally solidif our agreement. I have also attached with this little "memo" a copy of my new letter to Mayor Brown regarding the appointment of **two new members**, Sister MaryMae Himm and Jim Mitulski. With those two names, there is a total of **new** and **5 incumbents** names submitted for appointment. I am **please asking you** to help us prioritize these appointments for **this week**. As you know, it is crucial we have these members on board during prioritization or otherw we may suffer consequences from HRSA.

Please return this e-mail or give me a phone call at (415) 777-0333 and ask the reception to page me. I will be here un p.m. and tomorrow all day.

Thank you for all of your support. It was really a pleasure to meet you in person.

Laura Carcagno Guzmán
Membership Chair

Mayor's Letter-Appointments Ju...

Carcagno, Laura

From: Carcagno, Laura
Sent: Friday, July 09, 1999 4:13 PM
To: 'steve_kawa@ci.sf.ca.us'
Cc: 'bill_barnes@ci.sf.ca.us'
Subject: HIV Health Services Council Members' Terms

Hi Steve,

I saw you from afar today. The Senate hearing went really well...Good job!

I am writing you to see if you have had any time to look over my notes on our agreement regarding Members' Terms. I must tell you that I am really pressed to have your corroboration **in writing** so we can proceed with the nomination of incumbents **this coming Monday**. Council Members are expecting a special mailing with our formal agreement so they can make decisions concerning new terms. If you have not done so, I am urging you to please corroborate our agreement between **today and Monday before noon.**

In addition, we have not heard from you or Bill regarding the appointments of the **ten new members** and the **five incumbents** submitted to the Mayor's Office in June and July. I am a little worried that the appointments have not been processed by now. As we have stated to you and Bill before, it is crucial that these members sit at the table and help us make decisions **before prioritization** is over. Tom Calvanese has related to me that he has left a message with Taline today, to check whether the appointments are ready.

I would appreciate you respond to this e-mail ASAP.

Thank you so much for assisting us in these critical times. As I have heard Mayor Brown saying today "the need is greater now than ever before."

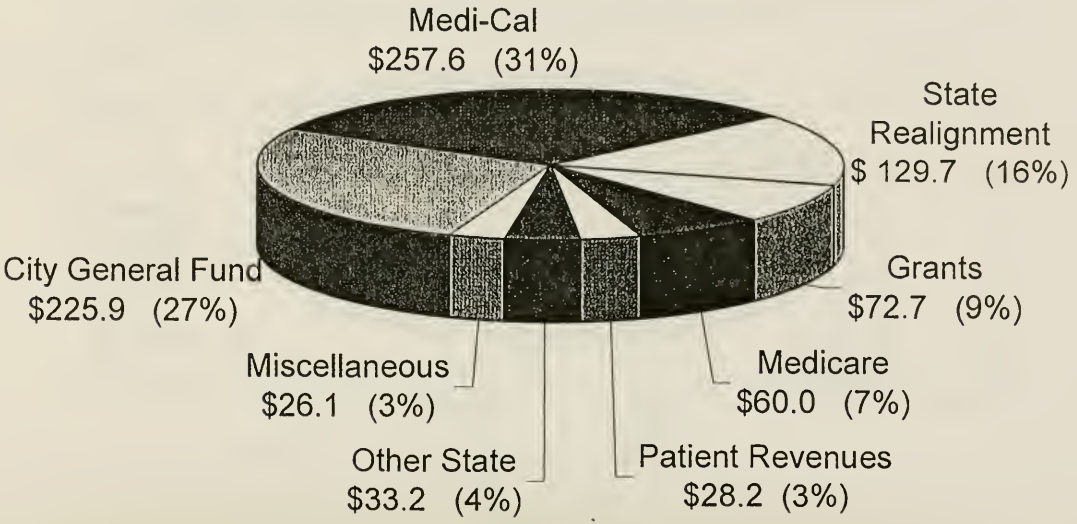
Very Sincerely,

Laura Carcagno Guzmán
Membership Chair
laurac@positiveresource.org

ATTACHMENT G

Department of Public Health

Sources of Revenue
FY 99-00 Budget
$833.4 Million
(In Millions)



Total budget $833.4 million

Department of Public Health
FY 99-00 Budget
Revenues By Source

	Community Health Network	Population Health & Prevention	Total	Percent
City General Fund	$ 117,489,164	$ 108,374,735	$ 225,863,899	27%
Medi-Cal	217,107,701	40,477,959	257,585,660	31%
State Realignment	-	129,700,000	129,700,000	16%
Grants	984,008	71,713,392	72,697,400	9%
Medicare	59,047,910	1,001,000	60,048,910	7%
Patient Revenues	27,970,772	287,020	28,257,792	3%
Other State	-	33,186,718	33,186,718	4%
Miscellaneous	91,711,743	(65,597,380)	26,114,363	3%
Total DPH	**$ 514,311,298**	**$ 319,143,444**	**$ 833,454,742**	**100%**

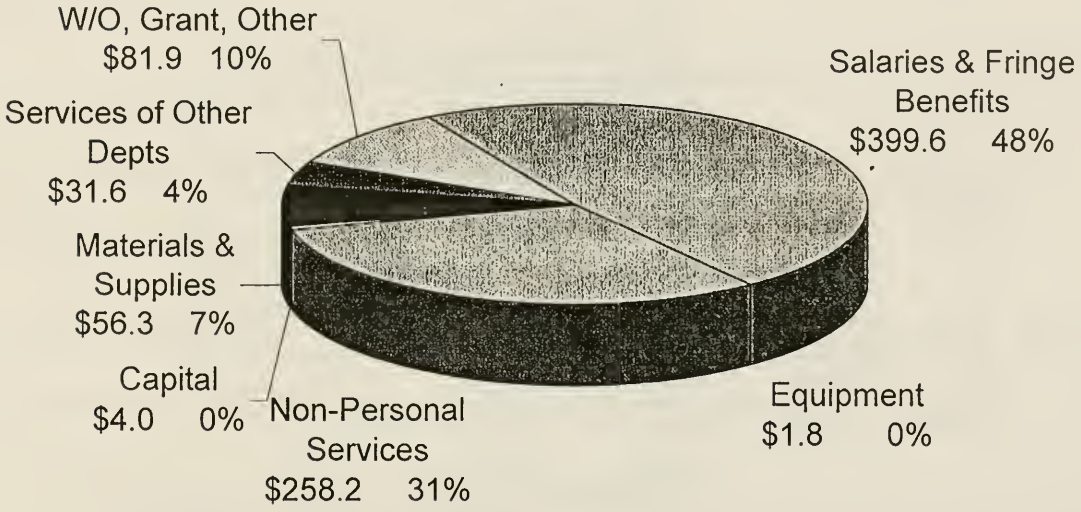
Source: Draft Annual Appropriation Ordinance (AAO)

Notes:

1. Medi-Cal (CHN) adjusted to exclude SB855, SB1255 & GME payments.
2. Misc revenues include dept transfer adjustments and SB855, SB1255 & GME payments.

Department of Public Health

Expenditures
FY 99-00 Budget
$833.4 Million
(In Millions)



Total budget $813.1 million

Department of Public Health
FY 99-00 Budget
Expenditures

	Community Health Network	Population Health & Prevention	Total	Percent
Salaries & Fringe Benefits	$ 333,183,776	$ 66,426,417	$ 399,610,193	48%
Non-Personal Services	113,406,813	144,763,775	258,170,588	31%
Materials & Supplies	52,279,692	4,083,230	56,362,922	7%
Equipment	1,704,938	90,000	1,794,938	0%
Facilities Maint & Capital	3,892,000	80,000	3,972,000	0%
Services of Other Depts	22,413,102	9,196,101	31,609,203	4%
W/O, Grant, Other	(12,569,023)	94,503,921	81,934,898	10%
Subtotal	$ 514,311,298	$ 319,143,444	$ 833,454,742	100%

Source: Draft Annual Appropriation Ordinance (AAO)

Notes:

1. Non-Personal Services for PHP excludes $98M SB 855 payment
2. W/O, Grant, Other includes $98M SB 855 payment

Highlights of FY 99-00 Budget Enhancements

- ❒ Mental Health - $5.2 million
- ❒ Homeless Services - $500,000
- ❒ Substance Abuse - $1.4 million
- ❒ San Francisco General Hospital - $4.5 million
- ❒ Children's Services - $1.5 million
- ❒ Lost Revenue SFGH/LHH w/ General Fund - $25 million
- ❒ Workers Compensation - $2.3 million
- ❒ Contractor COLA - $3.5 million

Department of Public Health
FY 99-00 Budget
Board Add Back Funding

	Amount	Reserved	Status	Dept	Division	Desription
Board Add Backs						
Children's Mental Health Initiative	$ 270,000	Yes	One time	HPH	MH	Additional services for children
Women's Community Clinic	34,000		One time	HPH	CHS	Funds for Rent
Mission SRO Collaborative	245,000	Yes	One time	HPH	Housing	Fire suppression
Names Project - Rent	21,000		One time	HPH	Central	Funds for Rent
Shanti - Full Circle of Care	75,000		One time	HPH	AIDS	HIV Case Management
Healthy Families Public Outreach	50,000		One time	HPH	Central	Outreach for additional State funded program
New Leaf Mental Health Services	75,000		One time	HPH	MH	Increased Mental Health
Bridge Project	67,000		One time	HCN	PC	HIV Homeless
Treatment on Demand	250,000		One time	HPH	CSAS	Medical Detox services
Asthma Resource Center	100,000		One time	HPH	CHS	BVHP Environ Center
SAGE Freestanding Facility	125,000		One Time	HPH	CSAS	New Facility Rehab
Methadone Access Physician Training	50,000	Yes	One time	HPH	CSAS	New Program start-up
Acute Diversion for Mental Health	300,000	Yes	One time	HPH	MH	Residential, acute diversion, Board and Care
Subtotal	$ 1,662,000					
To Be Added Back						
Native American AIDS	189,000			HPH	AIDS	To replace lost funding
Total	$ 1,851,000					

epartment: HPH : PUBLIC HEALTH

Expenditure by Program Recap

Programs:		Subfunds				
		1G AGF AAA General	1G S&A HWR Realignmnt	2S CHF NPR Children's	Project/Grant	Total Funding
HA	CENTRAL ADMINISTRATION	103,550,948	76,400,000		12,701,733	192,652,681
BC	CHF-MENTAL HEALTH			324,468		324,468
AL	CHILDREN'S BASELINE	18,810,451			1,310,270	20,120,721
HC	COMM HLTH - ADMINISTRATION	7,671,091			6,609,054	14,280,145
SP	COMM HLTH - COMM SUPPORT - HOUSING	2,486,043			754,548	3,240,591
SE	COMM HLTH - COMMUNITY SUPPORT - EAP	357,529			85,500	443,029
PE	COMMUNITY HEALTH - EMSA	1,119,603			504,837	1,624,440
PO	COMMUNITY HEALTH - OSH	943,261			216,491	1,159,752
PB	COMMUNITY HEALTH - BEHM	8,462,257			2,770,564	11,232,821
PD	COMMUNITY HEALTH - DISEASE CONTROL/AIDS	16,077,950			60,199,022	76,276,972
PH	COMMUNITY HEALTH - HEALTH EDUCATION	580,845			1,498,435	2,079,280
PM	COMMUNITY HEALTH - MATERNAL & CHILD HLTH	4,060,204			7,758,620	11,818,824
QM	MENTAL HEALTH - ACUTE CARE	5,279,642				5,279,642
AM	MENTAL HEALTH - CHILDREN'S PROGRAM	7,034,757				7,034,757
SM	MENTAL HEALTH - COMMUNITY SUPPORT	2,648,308				2,648,308
MM	MENTAL HEALTH - COMMUNITY CARE	102,652,167	53,300,000		5,191,838	161,144,005
IM	MENTAL HEALTH - EARLY INTERVENTION	155,544				155,544
BF	MENTAL HEALTH - EMERGENCY CARE	987,573				987,573
LT	MENTAL HEALTH - LONG TERM CARE	12,867,451				12,867,451
VS	SUBSTANCE ABUSE	1,194,284				1,194,284
QS	SUBSTANCE ABUSE - ACUTE CARE	2,541,629				2,541,629
SS	SUBSTANCE ABUSE - COMMUNITY SUPPORT	1,337,418				1,337,418
MS	SUBSTANCE ABUSE - COMMUNITY CARE	42,653,364			1,452,420	44,105,784
IS	SUBSTANCE ABUSE - EARLY INTERVENTION	1,892,949				1,892,949
TA	DEPARTMENTAL TRANSFER ADJUSTMENT	(120,740,099)	(129,700,000)		(6,859,525)	(257,299,624)
Total Expenditure by Program Recap		224,625,169		324,468	94,193,807	319,143,444

Department: HCN : COMMUNITY HEALTH NETWORK

		Subfunds			Project/Grant	Total Funding
		1G AGF AAA General	5H AAA AAA SFGH	5L AAA AAA Laguna Hon		
Expenditure by Program Recap						
Programs:						
CBD	CHF-PUBLIC HEALTH				257,762	257,762
FAL	CHILDREN'S BASELINE	4,436,761	7,262,938			11,699,699
DMF	FORENSICS - AMBULATORY CARE	20,706,310			678,204	21,384,514
DA5	LAGUNA HONDA - LONG TERM CARE			119,941,917	2,092,000	122,033,917
DBD	LAGUNA HONDA HOSP - COMM SUPPORT CARE			991,451		991,451
DBG	LAGUNA HONDA HOSP - ACUTE CARE			1,616,083		1,616,083
DHP	PRIMARY CARE - AMBU CARE - HEALTH CNTRS	33,723,583			5,435,813	39,159,396
DSH	PRIMARY CARE - COMM SUPP - IHSS				828,918	828,918
D1H	SFGH - ACUTE CARE - HOSPITAL		375,593,880		10,475,090	386,068,970
D1P	SFGH - ACUTE CARE - PSYCHIATRY		21,614,807			21,614,807
D1F	SFGH - ACUTE CARE - FORENSICS		2,008,054			2,008,054
D3A	SFGH - AMBU CARE - ADULT MED HLTH CNTR		2,884,985			2,884,985
D3F	SFGH - AMBU CARE - FAMILY HEALTH CENTER		2,542,626		349,077	2,891,703
D3G	SFGH - AMBU CARE - METHADONE GRANT				541,062	541,062
D3O	SFGH - AMBU CARE - OCCUPATIONAL HEALTH		1,604,057		665,051	2,269,108
D3W	SFGH - AMBU CARE - WOMEN'S HEALTH CENTER		1,959,840			1,959,840
D5E	SFGH - EMERGENCY - EMERGENCY		10,324,835			10,324,835
D5S	SFGH - EMERGENCY - PSYCHIATRIC SERVICES		4,105,715			4,105,715
D6P	SFGH - LONG TERM CARE - RF PSYCHIATRY		13,577,137			13,577,137
DTA	DEPARTMENTAL TRANSFER ADJUSTMENT		(129,814,658)	(2,092,000)		(131,906,658)
Total Expenditure by Program Recap		58,866,654	313,664,216	120,457,451	21,322,977	514,311,298

Future Trends in Health Care

- Continued risk of Federal & State reductions to reimbursement
- Increased compliance audits, audit disallowances & retroactive re-payments
- Number of uninsured will continue to increase
- HMO's beginning to limit services and reimbursement, thereby creating added pressures on safety net providers
- Increased expenses - salary and operating expenses
- Increased licensing and certification requirements for staffing, facility improvements, etc.

DPH Response to Funding Challenges

- ❒ Reduce reliance on institutional care / Increase community alternatives
- ❒ Re-engineer administrative services / Consolidate programs
- ❒ Develop rigorous compliance program to reduce audit disallowances
- ❒ Seek additional grant funds for prevention, community health assessments
- ❒ Advocate for increased Federal & State reimbursement
- ❒ Pursue initiative to create universal health care coverage

HIV HEALTH SERVICES PLANNING COUNCIL

July 26, 1999 4:30 - 7:30 PM

Room 201 - City Hall - 1 Dr. Carlton B. Goodlett Place

Agenda (revised 7/26/99)

I.	Call to order	4:30 PM
II.	Roll Call	4:32 PM
III.	Review and Approval of Agenda	4:35 PM
IV.	Review and Approval of Minutes from 5/26/99 and 6/28/99 - VOTE	4:37 PM
V.	General Announcements	4:40 PM
VI.	Public Comment	4:50 PM
VII.	Mayor's Liaison Report – Bill Barnes not present	5:05 PM
VIII.	Membership Committee - Laura Guzmán	5:15 PM
	• Nomination of incumbent members for additional term - VOTE	
IX.	Grantee Assessment Task Force	5:30 PM
	• Assessment Report - Barbara Rosa	
	Break	5:45 PM
X.	Counties Reports	
	• Marin - Kelly Wallace	6:00 PM
	• San Mateo - John Conley, Mary Jane Wood	6:10 PM
XI.		AIDS Office
	Report - Michelle Long Dixon	6:40 PM
	Prioritization update/upcoming meetings	7:20 PM
XII.	New Business	7:25 PM
XIII.	Adjourn	7:30 PM

SF Dept. of Public Health — AIDS Office, 25 Van Ness, 5th floor
City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

The sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council Members, are available for inspection and copying. For further information, call the Council's staff, 415-863-5462. The closest accessible BART Station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #71 Haight/Noriega, #9 San Bruno, F Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 923-6142. *Minutes of Meetings are tentative until formally approved by the Council.*

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422
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7/26/99
draft

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I. **Call to Order**
4:30 PM

II. **Roll Call**
Attachment A, Column 1

III. **Review and Approval of Agenda**
Agenda approved.

IV. **Review and Approval of Minutes**
Minutes of 6/28/99 were approved. KB, *DB, BC, VC, SJ, SO* abstained.

V. **General Announcements**

- *DB* distributed a flyer on a community forum about disclosure Saturday, July 31, 1999, Cafe DuNord, 2170 Market Street, 1-3 PM.
- *AM* announced a proposal for outcome evaluation studies. The SF Community Clinic Consortium has applied for funding for these studies. Contact him for further details.
- *TC* distributed the June-July 1999 issue of HRSA Care*ACTION* newsletter, which addresses HIV/AIDS and Homelessness.
- *LO'C* has a new work phone number: 241-5577. She also announced an open house for Action Point at the Rose Hotel, 6th Street, 5-7 PM, Thursday, July 29.
- *Laura Thomas* announced that the AIDS Office is working on grant proposals for (1) measuring unmet need; (2) co-morbidity factors, such as mental health and substance use, on cost of care; (3) The Office of Minority Health.
- *VC* has a new home phone number: 701-9958, and e-mail address: vcdiva@onebox.com.
- *DJ* discussed the terms of office of the council co-chairs. *NR*'s term ended 6/30/99, she has applied for reappointment to the council but not to continue as council co-chair. The terms for *TC* and *DJ* end September 30, 1999. They have decided not to apply for reappointment to the council. She recommended nominations for co-chairs take place at the 8/23 council meeting, and that elections be held at the 9/27 council meeting.
- *MS* distributed brochures for upcoming Treatment Education Certification Program trainings.

VI. **Public Comment**
None.

VII. **Mayor's Liaison Report**
None.

VIII. **Membership Committee Report**

- Nomination of incumbent members for an additional term.

LG reported that there has been no response from the Mayor's Office regarding reappointment of incumbent council members. *TC* said the council is currently not compliant with either HRSA's guidelines or the council bylaws in representation. He recommended not forwarding more names to the mayor until the five incumbent names currently waiting for reappointment are appointed and the council has an agreement on appointment procedure with the Mayor's Office.

- After discussion there was a motion **"to table the nomination of incumbent members for additional terms to the August 9 council meeting pending communication from the Mayor's Office regarding processing of the names already submitted."**

The motion passed unanimously. [Attachment A, Column 2]
MS pointed out that this item was being tabled for a reason, it was not procedural, and should be noted for the record as being based on a lack of response from the Mayor's Officer.

IX. **Grantee Assessment Task Force Report**
AM introduced *Barbara Rosa*, The Bernal Group, who gave a preliminary report on the progress of the Grantee Assessment. She distributed an overview reflecting things that might affect the prioritization process of the council. [Attachment B]
She said that people, both in San Francisco and elsewhere, have been very responsive and

have answered questions in detail. The assessment will contain recommendations from other EMAs regarding what has worked for them. The report will be anonymous. She said change was the word that kept coming up as a contributing factor in difficulties of the system. Changes in staff, in the character of the epidemic, and in funding levels, all have an impact on the system. Change also takes time in a system the size of this one. Initial recommendations were: (1) to avoid major programmatic changes next year; (2) prepare for major reductions in funding; (3) communicate clearly. She said word from Washington is that the reauthorization of the CARE Act will not be easy.

Discussion: *MS* said he would like to see the public notified of the results of the assessment. *Barbara* said that's the council's decision and responsibility. *LO'C* asked if there were funds for implementation of the report included in the cost of the assessment. *Barbara* said her scope of work did not include implementation. *TC* said he got a letter from Joe O'Neill at HRSA saying that, though the assessment goes beyond the basic requirement of the CARE Act, there is support from HRSA since the intent is to improve the delivery system to clients. *AM* said the final presentation of the assessment to the council will be October 25,1999. He hoped there would be time before that date for the AO to respond to the assessment in a separate document. *TC* said the AO would receive the assessment October 12. *DB* said the council would also need that time to evaluate the assessment.

X. **Counties Reports**

Marin Report, Kelly Wallace, Executive Director, Marin AIDS Project. *KW* gave a summary of funding for CARE Act Title I and Title II programs which totaled $1,506,758 this year. Almost two-thirds of that amount went to Primary Care, Case Management, and Direct Emergency Services.

Strengths of the project include:

- Integrated system of care.
- Integration of prevention/direct services.
- Innovation.

Weaknesses of the project include:

- Housing - no resources.
- transportation - all volunteer, many clients in rural areas.
- Mental Health.
- Small community - diversity issues.
- Legal services, financial assistance, acupuncture, and massage (from unmet needs of Client Needs Assessment).
- San Quentin - access is difficult.

Changes in the project this year include:

- Hot meals program ($110,000) was eliminated and replaced by:
  Severe hot meal need = $15,000; Alternative medication = $20,000; Transportation = $10,000; Medical Adherence = $15,000; Mental Health = $20,000; Food Pantry = $20,000; Case management = $10,000.

Discussion: *LG* asked how many people were served last year. *KW* said there were 224 clients served. *LO'C* said she had lived in Marin County and received good, flexible service that was innovative including a weekly spiritual group for people with HIV. One minus was that there were few openly HIV+ women.

San Mateo Report, John Conley, Deputy Director, San Mateo County Health Services. *JC* reviewed the charts included in the last council mailing for San Mateo County. He said the epidemic in SM County is more like the country as a whole than San Francisco. The HIV/AIDS population of northern SM County is largely white and Latino, in southern SM County it's mostly African American AIDS is the leading cause of death in the county, well above homicide, suicide and injury. San Mateo County AIDS Program contracts the following services: attendant care, food program, dental, residential services, and substance abuse treatment. The percentage of women with HIV is continuing to increase. Women account for 16% of living AIDS cases in the county but use a larger percentage of most AIDS Program services, up to 36% of residential services. People with HIV are getting older; there is a significant population (16%) over 50 now. African Americans account for 5% of the county's population, and 18% of the county's living AIDS cases, but use a larger percentage of most AIDS Program services, up to 63% of substance abuse treatment. 26% of clients in the program have no insurance, and over 40% are covered by Medi-Cal.

Successes of the program include:
- The health outreach team who provide transportation, communicate with clients, and act as a link between clients and the program.
- The development of a harm reduction center.

Challenges of the program include:
- Increasing diverse representation on the board.
- The Willow Clinic, in Menlo Park, a joint venture of the county, Stanford University, and the Veterans Administration. In some ways a success for each participant, (the county gets a higher reimbursement rate, Stanford gets access to the clients, the VA gets more community involvement) but a client needs assessment focus group was not positive about the services. The county cannot afford to duplicate all the services that are available at Edison Street at locations throughout the county.

MJW noted that the county's substance use treatment programs are available for all HIV clients within 24 hours of demand. Their programs are not as specific in regards to gender or ethnicity as those in San Francisco are. *JC* said that because there is not much diversity in programs there is more communication and cross referral between service providers.

XI. **AIDS Office Report**

Michelle Long Dixon distributed:
1st Quarterly Report to the HIV Health Services Planning Council. [Attachment C]
It included:
- Implementation Plan Update. *Michelle* said it would be important to assess three of the five categories for prioritization: (1) Ongoing Projects, (2) Projects, No Action Taken - No Additional Funds Allocated, and (3) No Action Taken.
- Contract Status Report. 75% of contracts are certified or in the process of being certified.
- Estimated unobligated funds to date. The balance for 1999-00 as of 7/23/99, after reserved funds for new RFPs, $74,229.

Russ Zellers distributed:
Summary of Annual Narrative Reports. [Attachment D] He said about 50% of contractors responded. Common gaps in service cited were housing, substance use, and mental health.
Utilization Report. [Attachment E] In the report UOS stands for Units Of Service, and UDC stands for UnDuplicated Clients.
Linkage of Substance Use and Outpatient Mental Health Services with Networks of Care. [Attachment F]

XII. **Prioritization update/upcoming meetings**

DJ reported on the last prioritization meeting and said there would be a continuation of that discussion Monday, August 2, 4:30-7:30 PM, 25 Van Ness Ave., Room 330-B. Topics will include peer and treatment advocacy, home care, peer support, and mental health.
Upcoming meetings include: Housing Committee, 8/4, 4-6 PM; PWA Caucus, 8/4, 5:30-7 PM; Membership Committee, 8/5 5:30-7:30 PM; Planning Council, 8/9, 4:30-7:30 PM; Prioritization, 8/16, 4:30-7:30 PM; Planning Council, 8/23, 4:30-7:30 PM. The final vote for prioritization will be at the 8/23 council meeting. *DJ* asked that members not wait until that meeting to ask questions about prioritization. *TC* said the goal is to build consensus before the 8/23 meeting.

XIII. **New Business**
- *VC* reviewed a memo on the use of the nation's prisons to house the mentally ill that will be included with the minutes. [Attachment G]
- *Laura Thomas* announced an invitation from the AIDS Foundation for lunch and a discussion of CARE Act reauthorization on August 4, 1999, at noon.

XIV. **Adjournment**

7:45 PM

All CARE Council & Committee meetings are held in accessible sites, and are open to members of the public. Participation of people living with HIV is strongly encouraged. Minutes of meetings and all information distributed to Council members are available for public inspection and copying. For further information contact Council staff at 415/863-5462.

HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

7/26/99		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Kirsten Balano	*KB*	P	Y										
Donald Bliss	*DCB*	P	Y										
Jeff Byers	*JB*	A											
Tom Calvanese	*TC*	P	Y										
Bart Casimir	*BC*	P	Y										
Veronika Cauley	*VC*	P	Y										
Julie Charubusapayon	*JAC*	A											
John Conley	*JC*	P	Y										
Luis De La Torre	*LDT*	P	Y										
Mark Dunlop	*MD*	P	Y										
Gene Gowdey	*GG*	P	Y										
Laura C. Guzman	*LCG*	P	Y										
Siddiq Jihad	*SJ*	P	Y										
Darrell Joe	*DCJ*	A											
Diane Jones	*DJ*	P	Y										
Sam Kaplan	*SK*	P	Y										
Tony Leone	*TL*	A											
Allen Meyer	*AM*	P	Y										
Lee Ann Monfredini	*LM*	A											
Norm Nickens	*NN*	P	Y										
Lisa O'Connor	*LO'C*	P	Y										
Loras Ojeda	*LO*	A											
Jorge Ortiz	*JO*	P	Y										
Stephan Oxendine	*SO*	A											
Alissa Riker	*AR*	P	Y										
Nilda Rodriguez	*NR*	P	Y										
Matthew Sharp	*MS*	A											
Susan Shea	*SS*	A											
Kelly Wallace	*KW*	P	Y										
Eric Whitney	*EW*	P	Y										
Mary Jane Wood	*MJW*	P	Y										

ATTACHMENT B

Project Overview

TITLE I GRANTEE ASSESSMENT

The Bernal Group

Barbara M. Rosa

Project Goals

- Assess the CARE Title I grantee's efficiency in rapidly allocating CARE Act funds to the areas of greatest need within the SF EMA
- Identify issues effecting the priority setting process
- Preliminary report–July 26, 1999
- Final report–September 27, 1999

Focus of Contractor's Questionnaire

- Requests for Proposals/Alternative Solicitations Process
- Contract /MOU Negotiation and Certification Process
- Invoicing and Reimbursements Process
- Program Monitoring Process
- Relationship with HIV Health Services (AIDS Office) and SFDPH

PROCESS

- Developed questionnaire for HIV Health Services staff–questions about operations, staff, budgets, etc.
- Developed questionnaire for Contractors/MOU providers (Service Providers)
- Developed questionnaire for Planning Council Members

PROCESS, cont.

- Met with HIV Health Services staff–direct verification of information provided by the department
- For comparison purposes:
  - Contacted Planning Councils at other EMAs
  - Contacted HIV Services at other EMAs

PROCESS, cont.

- Mailed Contractor/MOU provider questionnaire to 50 providers
  - Interviewed 12 Contractor and 2 MOU providers face-to-face
  - Total of 30 questionnaires completed
  - 20 typed pages of comments

PROCESS, cont.

- Mailed Planning Council Member questionnaire to 35 members
  - To date, conducted 5 face-to-face interviews with Planning Council members; 2 returns from mailed surveys

PRELIMINARY FINDINGS

- IMPACT ON PRIORITIES
- CHANGE
  - HIV Service delivery is a complex system--like a supertanker--can't turn on a dime
  - Ability of the system to react to yearly changes:
    - To HIV Health Services staff changes
    - To Service Provider staff changes

PRELIMINARY FINDINGS

- IMPACT ON PRIORITIES
- CHANGE
  - Ability of the system to react to changes in the character of the epidemic
  - Ability of the system to react to yearly changes in the funding levels

EMERGING ISSUES

- Communication between all parties
- Unfounded assumptions and lack of trust
- Inflexibility & timing of processes and procedures
- Competency & Accountability
  - HIV Health Services staff
  - Service Providers
  - Planning Council

INITIAL RECOMMENDATIONS

- Stay the course & avoid major changes this next year
- Prepare for the strong possibility of major reductions in funding
- Communicate clearly

ATTACHMENT C

HIV Health Services
1st Quarterly Report to the HIV Health Services Planning Council
July 26, 1999

IMPLEMENTATION PLAN UPDATE

Attached is a revised copy of the 1999-00 Implementation Plan. It is condensed and organized into the following sections: Projects Completed, Ongoing Projects, Projects, No Action Taken - No Additional Funds Allocated, No Action Taken, and No Action Taken - Unfeasible.

Based on 107 suggested projects for a multi-year period, the categorical breakdown to date is as follows:

Projects Completed	22%	(24)
Ongoing Projects	34%	(36)
Projects, No Action Taken - No Additional Funds Allocated	37%	(40)
No Action Taken	5%	(5)
No Action Taken - Unfeasible	2%	(2)

In prioritization for 2000-01, consideration should be given to projects in the categories of *Ongoing Projects, Projects, No Action Taken - No Additional Funds Allocated, and No Action Taken* to determine whether they should be continued, redirected or discontinued with realistic timeframes established.

CONTRACT STATUS REPORT

For the 1999-00 grant period, 3/1/99 through 2/29/99, 85 CARE contracts and MOUs and 125 exhibits are being developed and processed. Current contract status as of 7/23/99 is as follows:

Certified	44% (37)
In Certification Process	33% (28)
In Review/Negotiation Process	23% (20)

ESTIMATED UNOBLIGATED FUNDS TO DATE

The unobligated balance for 1999-00 as of 7/23/99 **$387,155**
This balance is composed of the following:

Reserved for negotiation of contracts as a result of new RFPs $312,926

- *Harm Reduction/outpatient*
- *Monitored Outpatient/Residential Detox*
- *Technical Assistance*

Resulting from the contract negotiation process $74,229

This balance may increase or decrease as a result of continuing contract negotiations.

HIV Health Services Implementation Plan
(Beginning 1999-2000: Multi-Year)

Created
11/19/98
Revised 7/25/99
(Includes project updates)

This implementation plan incorporates the program changes proposed by the HIV Health Services Planning Council during its prioritization process for 1999-2000 funding as well as projects proposed by the grantee for the same period.

Key to Symbols:

(-) To be achieved if funding is decreased
(=) To be achieved if funding is level
(+) To be achieved if funding is increased
(UX) To be achieved if unexpended funds are available

PROJECTS COMPLETED

Health Care

Sub-category: **Primary Care**

1. Develop standards of care for provision of Primary Care services to persons with HIV/AIDS (=) **DONE – NIH guidelines; compliance w/JCAHO standards**

2. Implement the standards of care in all funded services (=)
DONE – NIH guidelines made available; compliance w/such in directives required in 1999-00 contracts

4. To include adherence to treatment as an impact/outcome objective in CARE funded services contracts (=,+) **Included where appropriate; contractors informed of this requirement at the beginning of the contracting cycle**

5. To expand the integrated service model of care to include more services for African Americans, Latinos, and the incarcerated/newly released population. Services should be expanded by scope and sites of access (=,+) **Done for African American population through CBC initiative; to be expanded to Latinos through use of unobligated funds**

Sub-category: **Home Health: Home-based**

1. To provide in-home outreach and education to support adherence to multi-drug antiretroviral combination therapies (+) **INCLUDED IN CONTRACT LANGUAGE**

Sub-category: **Home Health: Residential Facility-Based**

1. Conduct an evaluation of the utilization of services within this subcategory, especially infusion and home hospice care, and redirect funds if the services are not being utilized at an appropriate level (=,+) **DONE**

2. To reorganize services/contracts so that residential facilities have direct control over home health care provided at their facilities. (=,+) **DONE**

Case Management

Sub-Category: **Case Management**

4. Increase availability of case management services after hours and on the weekend (+) **NO ADDITIONAL S; SOME CONTRACTORS HAVE EXPANDED HOURS**

5. Make available more vouchers for transportation and household goods (UX) **DONE**

Client Advocacy

Sub-category: **Treatment Advocacy**

3. Link to case management (=) **DONE**

Sub-category: **Money Management**

1. Include in integrated service models (=) **LINKED THROUGH HOUSING**

Direct Financial Emergency Assistance

Sub-category: **Direct Financial Emergency Assistance**

1. To relax the eligibility restrictions on the types of needs that can be covered under this service (=) **DONE**

Day/Respite/Childcare

Sub-category: **Children's Programs and Childcare**

2. To increase childcare access and flexibility, including on-call childcare (=,+) **INCREASED CAPACITY OF PROVIDER**

5. To make available more vouchers for transportation (UX) **DONE**

Housing

Subcategory: **Emergency Housing**

2. Link emergency housing to integrated services networks and to mobile Case Management and Peer Advocacy Models (=,+) **DONE**

3. To provide short-term storage facilities for homeless PWA or those residing in emergency housing (+) **INCLUDED IN ACTION POINT CENTER (OPENED 7/99)**

Sub-Category: **Housing Subsidies: Full and Shallow**

3. To conduct an evaluation of the utilization of services within this sub category, and redirect funds to emergency housing if the services are not being utilized at an appropriate level (=,+) **DONE**

5. To increase decentralized access to housing subsidies through the integrated services network and to mobile Case Management and Peer Advocacy models (=,+) **DONE**

Sub-Category: **Residential Hospice**

2. Re-evaluate residential hospice versus home health categories (=) **DONE**

Mental Health

Sub-Category: Long/short Term MH Services (Outpatient)

2. To support better integration of funding sources - including shifting CARE support services and clients to Medi-Cal support when feasible (=,+) **DONE**

4. Cut services for the severely mentally ill and transition clients to CMHS supported services (-) **DONE**

5. Evaluate reimbursement cap for services in order to make comparable to Medi-Cal rates (-) **DONE; MEDI-CAL RATES WERE CLOSE TO CARE RATES**

8. To conduct an evaluation of the utilization of services within this subcategory and redirect funds if the services are not being utilized at an appropriate level (=) **DONE**

Substance Abuse

Sub-Category: Residential Long-term

1. Combine with residential short-term category and create variable length of stay services, with analysis of need, and limit based utilization (=) **DONE**

ONGOING PROJECTS

Health Care

Sub-category: **Primary Care**

3. To evaluate changes in the provision of primary care and include an impact/outcome analysis component in the contractual scope of work (=,+) **Impact/outcome analysis included in contractual scope of work**

7. Integrate the availability of Action Point Adherence Centers (APAC) into the models of integrated service provision (=,-) **First Action Point Center opened 7/99**

Sub-category: **Home Health: Home-based**

3. To conduct an evaluation of the utilization of services in this subcategory and redirect funds if the services are not being utilized at an appropriate level. (=,+) **BEGINNING THIS YEAR CONTRACTORS HAVE BEEN ALLOWED TO REDISTRIBUTE FUNDS IN THIS CATEGORY BASED ON CHANGING UTILIZATION PATTERNS**

Case Management

Sub-Category: **Case Management**

1. Evaluate changes in the provision of case management and include an impact/outcome analysis component (-) **ONGOING – STANDARDIZED LANGUAGE RE: EXPECTED IMPACT/OUTCOME INCLUDED IN 1999-00 CONTRACTS; DATE FOR MTG W/ CM SCHEDULED FOR AUG 1999**

2. To achieve greater integration with client advocacy (=) **ONGOING THROUGH CONTRACT NEGOTIATION; BENEFITS COUNSELORS ARE OUTSTATIONED AT AGENCIES THAT ALSO PROVIDE CASE MGMT SVCS AS WELL AS INTEGRATED PROVIDER SITES**

6. Provide more training in case management standards (UX) **IN PROGRESS; DATE TBD**

7. Provide training in harm reduction principles (UX) **WORKSHOP CONDUCTED BY CSAS IN APRIL 1999; CATEGORICAL POSITION PAPER TBD**

Sub-category: **Peer Advocate Outreach**

1. Evaluate changes in the provision of peer advocacy services and include an impact/outcome analysis component and an analysis of the cost effectiveness of the model, returning funding to the Buddy/Companion category, if appropriate (=) **ONGOING; MTG W/PEER ADVOCATES SCHEDULED FOR AUG 1999**

3. To increase availability of peer advocacy services after hours and on the weekend (+)**NO ADDITIONAL $; SOME CONTRACTORS HAVE EXPANDED HOURS**

Client Advocacy

Sub-category: **Treatment Advocacy**

6. To provide training for treatment advocates (UX) **ONGOING THROUGH TREATMENT EDUCATION AND CERTIFICATION PROGRAM**

Sub-category: **Benefits Counseling**

1. Link to case management services (=) **ONGOING THROUGH CONTRACT NEGOTIATION**

Sub-category: **Legal/Immigration Assistance**

1. Link to case management services (=) **ONGOING THROUGH CONTRACT NEGOTIATION**

Direct Financial Emergency Assistance

Sub-category: **Direct Financial Emergency Assistance**

2. To decentralize access to direct financial emergency assistance (=)**ONGOING**

3. Develop a short-term eviction prevention program (=,+) **TO BE CREATED W/UNLIQUIDATED FUNDS**

4. To create access to direct financial emergency assistance services for the recently incarcerated/released (=,+) **NEED TO DEVELOP MOU BETWEEN CBC PROVIDER AND DIRECT FINANCIAL EMERGENCY ASSISTANCE PROVIDER**

5. To increase the annual financial limit per client for direct financial emergency assistance (+) **ONE TIME INCREASE THROUGH USE OF UNLIQUIDATED FUNDS FROM 1998-99.**

Food

Sub-category: **Food Bank /Meal Delivery**

1. To provide more complete nutrition/meals for the homebound (+) **NO ADDITIONALS; AGENCY NEEDS ASSESSMENT COMPLETED 6/99 OR 7/99**

Day/Respite/Childcare

Sub-category: **Children's Programs and Childcare**

1. Develop a site-based childcare program (=,+) **ONGOING; ADDITIONAL FUNDS TO BE ALLOCATED THROUGH USE OF UNALLOCATED FUNDS FROM 1998-99; ADDITIONAL ASSESSMENT NEEDED**

Program Support

Sub-category: Technical Assistance

1. To provide technical assistance and training for CBOs (+,UX) **ONGOING; RFP TBD; ADDITIONAL TRAINING TO BE PROVIDED THROUGH USE OF UNLIQUIDATED FUNDS FROM 1998-99.**

Sub-category: REGGIE/ACE

1. To purchase equipment (including computers) for agencies participating in REGGIE (=) **ONGOING**

Transportation

Sub-category: Transportation

3. To investigate the development of a contract with one or more taxi companies to provide transportation for PWAs (=,+) **ONGOING**

Overall

1. Develop an ongoing educational media outreach campaign about available services (=,+)**TO BE DEVELOPED THROUGH USE OF UNLIQUIDATED FUNDS FROM 1998-99.**

2. Incorporate harm reduction principles across all service categories to make services more accessible to active users (=,+) **NO ADDITIONAL $; INCORPORATED INTO 1999-00 CONTRACTS**

Housing

Subcategory: Emergency Housing

1. To expand decentralized access to emergency housing vouchers and shallow rent subsidies through linkages with expanded integrated service networks and at drop-in centers (=,+) **ADDITIONAL $ FOR EMERGENCY HOUSING VOUCHERS REQUESTED FROM UNLIQUIDATED FUNDS FROM 1998-99**

4. Fund more emergency housing vouchers (UX) **ADDITIONAL $ FOR EMERGENCY HOUSING VOUCHERS REQUESTED FROM UNLIQUIDATED FUNDS FROM 1998-99**

Sub-Category: Housing Subsidies: Full and Shallow

1. To create a reserve fund for minor repairs to units damaged by subsidy tenants (=, +) **NO ADDITIONAL FUNDS; ADDITIONAL $ FOR APPLIANCE REPLACEMENT REQUESTED FROM UNLIQUIDATED FUNDS FROM 1998-99**

Sub-Category: **Transitional Housing**

1. To increase decentralized access to transition housing through the integrated service networks and to mobile Case Management and Peer Advocacy models (=,+) **NO ADDITIONAL $; FURTHER ANALYSIS NEEDED**

2. To investigate master leasing of buildings, sublet with support services (=,+); **ONGOING**

Sub-Category: **Practical Support**

1. Insure that practical support services are provided within housing facilities, especially within SRO emergency housing (=) **ASSESSMENT ONGOING THROUGH SPECIFICATION OF PRACTICAL SUPPORT TIME IN CONTRACTS**

Mental Health

Sub-Category: **Long/short Term MH Services (Outpatient)**

1. To create better integration with other services, including the integrated service networks (=,+) **ONGOING; HELD MEETINGS WITH ISP & MH & SA PROVIDERS – DEMONSTRATED IMPROVEMENT OF LINKAGES NOT ACHIEVED**

Sub-category: **Residential Care**

2. Provide training for service providers on dementia/cognitive impairment (+) **TO BE CONDUCTED WITH UNLIQUIDATED FUNDS FROM 1998-99**

Substance Abuse

Sub-Category: **Residential Long-term**

3. To provide training for service providers on integrating harm reduction principles into service provision (=,UX) **WORKSHOP CONDUCTED BY CSAS IN APRIL; ADDITIONAL TRAINING UNDER CONSIDERATION; NO ADDITIONAL $**

4. To create better linkages of providers into networks of care (=) **ONGOING; HELD MEETINGS WITH ISP, MH, AND SA PROVIDERS - DEMONSTRATED IMPROVEMENT OF LINKAGES NOT ACHIEVED**

Sub-Category: **Residential Short Term**

4. To encourage more linkages between jail and community-based services (=,+) **INCORPORATED INTO SOME CONTRACTS; AO APPLYING FOR ADDITIONAL GRANT $; WILL OCCUR FOR AA/LATINO COMMUNITIES THROUGH CBC PROJECT**

5. To provide furnishings for residential programs (UX) **ADDITIONAL $ FOR APPLIANCE REPLACEMENT REQUESTED FROM UNLIQUIDATED FUNDS FROM 1998-99**

Sub-Category: Overall

1. To coordinate substance abuse services across funding streams - working with CSAS' Treatment on Demand to leverage services, combine services, combine funding streams, and plan for the system as a whole. Linkages should be made to housing and other services funded elsewhere (especially youth services) (=,-,+) **NO ADDITIONAL $; JOINT COUNCIL COMMITTEE CONTINUES TO MEET; NEED FOR ADDITIONAL COLLABORATION BETWEEN DPH SECTIONS (AO/CSAS)**

NO ACTION TAKEN - NO ADDITIONAL FUNDS ALLOCATED

Health Care

Sub-category: **Primary Care**

6. Develop drop-in centers for primary care services (+) **NO ADDITIONAL $**

Sub-category: **Dental**

1. Evaluate the need for and potential capacity to include dental services within the integrated model of care (=,+); **NO EVAL CONDUCTED – New Dental model created for 98-99; NO ADDITIONAL $**

Sub-category: **Pharmaceuticals**

1. Evaluate the need for and potential capacity to include pharmaceutical services within the integrated model of care (=,+)**NO EVAL CONDUCTED; NO ADDITIONAL $**

Sub-category: **Complementary Therapy**

1. Evaluate the need for and potential capacity to include complementary treatment services within the integrated model of care (=,+) **NO EVAL CONDUCTED; NO ADDITIONAL $**

2. To expand the integrated services model of care to include the provision of complementary treatment to the homebound (+) **NO ADDITIONAL $**

Sub-category: **Home Health: Home-based**

2. Provide primary care to homebound PWA through a mobile health team (+) **NO ADDITIONAL $**

Case Management

Sub-Category: **Case Management**

3. To increase services for any populations which are currently underserved (+)**NO ADDITIONAL $**

Sub-category: **Peer Advocate Outreach**

2. Add more peer advocacy services to the integrated services models (+) **NO ADDITIONAL $**

Client Advocacy

Sub-category: **Treatment Advocacy**

2. To provide more services for newly diagnosed PWAs (+) **NO ADDITIONAL $**

4. To provide more treatment advocacy services for African American and Latino populations (+)**NO ADDITIONAL $**

5. To provide treatment focused workshops for newly diagnosed PWA's (UX) **NO ADDITIONAL $**

Food

Sub-category: **Food Bank /Meal Delivery**

2. To develop communal kitchen/cooking facilities (+) **NO ADDITIONAL $**

3. To purchase food storage facilities/refrigerators for the marginally housed/homeless (UX) **NO ADDITIONAL $**

Sub-category: **Nutritional Counseling**

1. Link nutritional counseling to treatment advocacy and primary care (including complementary therapies) (=,+) **NO ADDITIONAL $; NOT DONE**

Adoption/Foster Care

Sub-category: **Adoption/Foster Care**

1. To develop better services for adolescent placement in foster care (=,+)**NO ADDITIONAL $; NOT DONE**

Day/Respite/Childcare

Sub-category: **Adult Day Health Care**

1. To develop a program for people with moderate dementia (+)**NO ADDITIONAL $**

Sub-category: **Children's Programs and Childcare**

3. To increase the reimbursement rate for childcare providers (+)**NO ADDITIONAL $**

Transportation

Sub-category: **Transportation**

1. To develop a dispatch system for the system-wide van pool (=,+) **NOT DONE; NO ADDITIONAL $**

4. To develop an inter-county transportation pool (+) **NO ADDITIONAL $**

5. To make available more vouchers for transportation (UX) **NO ADDITIONAL $**

Housing

Sub-Category: Housing Subsidies: Full and Shallow

2. To provide better information to those seeking housing, which includes development of a list of landlords who accept subsidies (+,UX) **NO ADDITIONAL $**

4. To create an outreach and education program for landlords and clients - landlords: special needs of PWA tenants; clients: what are their rights, how to appeal to landlords, etc. (+,UX) **NO ADDITIONAL $**

Sub-Category: Residential Hospice

1. To provide additional funds to cover increased operating costs (+) **NO ADDITIONAL $**

Sub-Category: Transitional Housing

3. To increase the availability of housing operated using harm reduction philosophies for substance users (+)**NO ADDITIONAL $;**

Sub-Category: Financial

1. To create supportive services for women and children that are linked to primary care and other necessary and appropriate services (=)**NO ADDITIONAL $**

Sub-Category: General

1. To provide COLA to housing providers to keep pace with increasing housing costs (+)**NO ADDITIONAL $**

Mental Health

Sub-Category: Long/short Term MH Services (Outpatient)

3. To provide one-time funds for operating costs for mobile teams (UX) **NO ADDITIONAL $**

7. To fund on-call, after hours psychiatric services (+)**NO ADDITIONAL $**

9. Increase category proportionally (+)**NO ADDITIONAL $**

Sub-Category: Psychiatric Consultation

1. To increase psychiatric assessments, with triage, at more locations, and with more linkages. Possible settings include primary care, treatment facilities, SROs, shelters, etc. (+)**NO ADDITIONAL $**

Sub-category: **Crisis Services**

1. Increase Services Proportionally (+)**NO ADDITIONAL $**

Sub-category: **Residential Care**

1. To fund/create a residential facility for PWAs with moderate dementia/cognitive impairment (+)**NO ADDITIONAL $**

Substance Abuse

Sub-Category: **Residential Long-term**

2. Create more services for women with families (keeping children with them) (=) **NOT DONE; NO ADDITIONAL $ - INCREASED COST TO ACCOMMODATE FACILITY TO INCLUDE CHILDREN TO MEET TIGHTER LICENSURE REQUIREMENTS, ADDITIONAL STAFF REQUIRED TO ASSURE CLIENT/STAFF RATIO AND TIGHTER SCREENING OF POTENTIAL CLIENT BASE IF CHILDREN PRESENT (CRIMES OF ABUSE OR ENDANGERMENT) AS WELL AS THE NEED TO INFORM CLIENTS OF REPORTING REQUIREMENTS IF CHILD ABUSE/NEGLECT IS DETERMINED**

Sub-Category: **Residential Short Term**

1. To redirect some funds into a residential harm reduction model (+)**NO ADDITIONAL $**

2. To evaluate the cultural appropriateness of programs and to provide training where needed (=,+,UX) **NOT DONE; NO ADDITIONAL $; TO BE ADDRESSED THROUGH SFDPH "POLICY 24" INITIATIVE**

4. Create more services for MSM/IDU'S (+)**NO ADDITIONAL $**

Sub-Category: **Out Patient Counseling**

1. Develop programs as alternatives to drug use - recreational, etc. - especially for youth (+) **NO ADDITIONAL $**

2. To develop more services for transgender PWAs (+) **NO ADDITIONAL $**

4. To create a drop-in center, which includes outpatient counseling as one of the services offered (+) **NO ADDITIONAL $**

Sub-Category: **Detox**

6. Encourage more utilization of alternative detox services, such as acupuncture (+) **NO ADDITIONAL $**

NO ACTION TAKEN

Health Care

Sub-category: **Pharmaceuticals**

2. Evaluate the need for and potential capacity to contract out a portion of non-ADAP funding to the Mental Health Section for services to persons with HIV/AIDS within the Mental Health System of Care (-,UX); **ASSESSMENT NOT DONE; CMHS CONTINUES TO PROVIDE PSYCHOTROPIC MEDICATION TO HIV+ CLIENTS IN THEIR SYSTEM**

Day/Respite/Childcare

Sub-category: **Children's Programs and Childcare**

6. To conduct an inventory of child care potential availability and need (=) **NOT DONE**

Program Support

Sub-category: **REGGIE/ACE**

2. To conduct an evaluation of the REGGIE project (=) **NOT DONE**

Transportation

Sub-category: **Transportation**

2. Conduct an evaluation of current van service providers (=) **NOT DONE**

Mental Health

Sub-Category: **Long/short Term MH Services (Outpatient)**

6. Link psychiatric case management services to Psychiatric Emergency Services (PES) (=,+) **NOT DONE; NEEDS MORE ASSESSMENT**

NO ACTION TAKEN - UNFEASIBLE

Day/Respite/Childcare

Sub-category: **Children's Programs and Childcare**

4. To develop a voucher program for childcare services (UX) **DETERMINED UNFEASIBLE FOR ONE-TIME UNLIQUIDATED FUNDS**

Substance Abuse

Sub-Category: **Out Patient Counseling**

5. Make available child care vouchers, which can be utilized while PWAs are receiving outpatient care (UX) **VOUCHERS DETERMINED TO BE UNFEASIBLE WITH ONE-TIME UNLIQUIDATED FUNDS**

ATTACHMENT D

Memorandum

Date: June 28, 1999

To: HIV Health Services Planning Council

Through: Russ Zellers, Assistant Director, DPH, HIV Health Services

From: Dean Goodwin, Management Assistant, DPH, HIV Health Services

Re: Summary of Annual Narrative Reports, ~~Health Care only~~

Following is the requested summary of the Annual Narrative Reports from CARE-I funded providers for FY-98/99.

The information for program exhibits was sorted based on the FY-98/99 Service Sub-categories. Integrated Services programs that were started after the beginning of the fiscal year, are listed separately in the Health Care and Case Management categories.

Of the six questions from the report summarized for the HIV Health Services Planning Council, three questions will be presented by service sub-category (wait lists [all programs], progress of meeting impact objectives [new only], and significant changes in program [new only]). Recurrent themes and important perspectives will be presented. Obviously, not all responses from each agency to the questions could realistically be presented in a summary memo format.

The other three questions (system wide gaps in service, involvement of people with HIV/AIDS, and technical assistance needs) will follow and no distinctions by service category will be made.

Not all programs submitted their Annual Narrative Reports. In each service category section, it will be noted how many programs responded and how many programs were contained in that service sub-category for FY-98/99.

HEALTH CARE

PRIMARY CARE

Of the 12 programs in this service category, 10 submitted annual narratives, none of these four were new programs.

Inclusion of Wait Lists (All Programs):
Of the four programs, two did not utilize a wait list, and one of those cited that all clients are seen within 48 hours of contacting the clinic. The other two programs utilize a list for those clients wishing access to methadone maintenance, both stated that the list has an average of 20 names and the wait time varies between 2 to 4 weeks.

DENTAL

Two of the three programs in this service sub-category returned their reports, both were new programs.

Analysis of Impact Objectives (New Programs Only):
Objectives were met. One hundred percent of clients will be assessed as to whether they have a primary care provider, and referred to one if they do not. All clients have received dental evaluations. All clients have received a diagnosis and treatment plan.

Changes Made in Program (New Programs Only):
No significant changes.

Inclusion of Wait Lists (All Programs):
No wait lists were utilized.

COMPLIMENTARY THERAPIES

Four of the five programs in this sub-category returned their reports, none of them were new programs.

Inclusion of Wait Lists (All Programs):
Three of these four programs maintained a wait list. They indicated that the average numbers of clients on the wait lists was between 30 to 60, with the average wait time from four to six months. One program indicated a prioritizing of clients based on medical acuity and need, especially for those multiply diagnosed or marginally housed.

HOME HEALTH

There are six programs listed in this service sub-category for FY-98/99, three returned their reports. None of these were new programs.

Inclusion of Wait Lists (All Programs):
No wait lists were utilized.

INTEGRATED SERVICES

Five of the 11 new programs in this category completed their narrative reports. All were new programs

Analysis of Impact Objectives:

All impact objective are accomplished or on target.

In all areas where a base-line for measuring clients self-reported quality of life were established those objectives were met:

- Percent of clients not lost to follow-up
- clients to be prescribed prophylaxis therapy and antiretroviral therapy
- established on-going medical care
- case management referrals have been met
- improvements in quality of life
- prevented psychiatric hospitalizations

Changes Made in Programs:

Most Integrated Services programs cited the following:

- Reduction of funding for case management resulted in lower level of services to clients, especially those who were monolingual/non-English speaking, dually or triply diagnosed and/or marginally housed.
- Unanticipated increases in the acuity levels of clients resulted in lower numbers of unduplicated clients served than contracted.
- A shift had to be made from providing less intensive services for a larger number of clients to providing more intensive services to fewer clients.
- Streamlining of emergency housing vouchers and shallow rent subsidies through SFAF has proven effective and no undue delays were reported.
- Several programs noted that Mental Health and Substance Use services were not funded as part of the delivery system, but became a necessary component of integrated services for the population served. therefore successful MOU partnerships were created to deliver on-site short-term therapy. Additional linkages for on-site psychological/psychiatric evaluations and substance use services were being formed.
- Multiply diagnosed HIV+ individuals requiring drug treatment services had their admissions prioritized in one program due to many integrated models of care not providing chemical dependency treatments and because of long waiting lists at these centers.

Reduction of Wait Lists:

Of the five programs, only one maintained a wait list. This program reported an average of 15 [illegible] the list. Clients at [illegible] are expected to be enrolled in the program after waiting approximately one month for services. It is unclear at this point how long clients will remain on the waitlist and how many more clients may be signed onto the waitlist for FY99 00. The wait list was only recently required.

HOUSING

EMERGENCY VOUCHERS

Three of the five programs in this service category returned their reports, one of these was a new program.

Analysis of Impact Objectives (New Program Only):
Data for final quarter reports was still being collected and compiled on impact objectives regarding the movement of clients toward more secure housing and will soon be sent to AIDS Office. These goals regarding percentages of clients served and transitioned into housing were on target. Respondents of client satisfaction surveys demonstrated overall satisfaction to be very high (95% stating that they were "Very Satisfied" or "Satisfied" with the services they received.) While most clients expressed satisfaction with the program, and the stability brought about by the housing subsidy, some respondents were not happy with the results of the standardization process, during which all clients subsidy share of cost was reviewed and in some cases appropriately recalculated.

Changes Made in Program (New Program Only):
Much work in the early part of the new program was required to explain to the clients and providers that the emergency housing program had a necessary change in philosophy and approach, which was now designated for use in conjunction with a plan to stabilize clients' long-term housing rather than as a respite or last resort for clients without housing. The impact upon referring hotels also required much communication. The rental subsidy program also required much communication for those clients who were transferred over with the program change, a considerable effort to meet with clients, collect information and moving toward program standardization was required. The new program's ability to provide a rental subsidy for a room in an SRO hotel has expanded some clients' options, as they may have not been able to successfully locate a rental unit otherwise.

Inclusion of Wait Lists (All Programs):
None of the three programs reported utilization of a wait list.

RESIDENTIAL HOSPICE

[illegible] program in this sub-category report was sent.

[illegible] Wait Lists (All Programs):
[illegible] generally [illegible] [illegible] period [illegible] days up to

TRANSITIONAL HOUSING

Only one program in this sub-category, the report was sent, it was not a new program.

Inclusion of Wait Lists (All Programs):
Wait list is utilized, generally 15 to 20 clients on the wait list for a period of two to three months.

SUPPORT SERVICES/ FINANCIAL

There were five programs in this service sub-category, two sent in reports, one of which was a new program.

Analysis of Impact Objectives (New Program Only):
No unduplicated clients were lost to follow-up. During the contract period, all participants served were referred and received a minimum of three services. Continuing clients demonstrated improvement in utilization of community resources, which has substantially impacted the quality of life of participants and ahs assisted families in the maintenance of their housing placement.

Changes Made in Program (New Program Only):
In some cases direct advocacy, the case manager accompanying the client to scheduled or emergency meetings, was implemented. A significant increase in referrals for monolingual Spanish speaking families during the contract period have lead to the challenge of securing program staff representative of the client population served, particularly as peer advocates.

Inclusion of Wait Lists (All Programs):
For the new program, a wait list is maintained when demand for services exceeds program capacity. The average number on that wait list is 10 families of approximately 30 individuals. Waiting time is dependent on staff capacity, generally varies between two to six months.
In the existing program, Case Management does not maintain a wait list, because all clients are seen. A wait list for available beds does occur occasionally, usually not for more than 1 to 3 clients, who are generally referred elsewhere for services.

PERMANENT HOUSING

Of the 11 programs in this sub category, five completed narrative reports, one of these was a new program.

Analysis of Impact Objectives (New Program Only):
[illegible] reported from the first three quarters of the contract period indicated [illegible] impact [illegible] Manager

Changes Made in Program (New Program Only):
The allocation of specific numbers of vouchers and shallow rent subsidies to each program, led to rationing and under-utilization of the subsidies and that the subsidy was too small for clients to realistically use in this housing market. The program was modified to increase the amount of the subsidy, to expand client eligibility, and to discard agency-specific allocations. Due to unexpended subsidy funds, the program was also modified to transfer those funds to vouchers

and allow clients more access to emergency housing. A pool of vouchers was created for clients who would benefit from expanded voucher eligibility as a bridge toward more permanent housing.

Inclusion of Wait Lists (All Programs):
None of these five programs utilized a wait list. The wait list is maintained by SFAF as part of the Housing Wait List. Average number of clients who have chosen low-level support on this list is approximately 5,000. The average waiting time is two to three years.

One program did state that Permanent Housing vacancies are rare, when spaces are available a transitional housing client who is stable is transferred into that vacancy.

FOOD SERVICES

There are four service subcategories that fall in this section, containing six different programs from three different agencies. Five of those programs completed their narrative reports, only one was for a new program.

Analysis of Impact Objectives (New Program Only):
October 1998 Membership Satisfaction Survey showed an increase in overall program satisfaction from the previous year. In 1997 overall satisfaction was at 73%, which increased to 86% by the next year.

Changes Made in Program (New Program Only):
The main change was the challenge of how to enter UOS data for a congregate meal in the client database.

Inclusion of Wait Lists (All Programs):
None of the food programs utilized a wait list for services.

MENTAL HEALTH SERVICES

[illegible] / SHORT TERM PSYCHOTHERAPY

[illegible] were 15 programs listed in this sub-category for FY 1998, eight of them completed their [illegible] reports. One of these was a new program.

[illegible]nalysis of Impact Objectives (New Program Only):
A new evaluative tool for the quantifying of many mental health measures was still being developed at time of report and should be fully operational by this year. Client satisfaction with sessions was very high.

Changes Made in Program (New Program Only):
Instability of government services has had a severe adverse impact on availability of services and the number of clients accessing those services. Many clients are reluctant to participate due to instability of program funding and are reluctant to go to other programs for fear of discrimination or cultural insensitivity.

Inclusion of Wait Lists (All Programs):
Five of the eight programs reporting did not utilize wait lists. For two of the programs utilizing a wait list, it was reported that the average number on the wait list varied between 2 to 15 and that the approximate wait time was 4 to 5 weeks. The third program reported that the number of clients on the wait list varied throughout the year generally, between 4 and 8. Wait time for internship therapy program is 2 weeks, for volunteer therapist program the average wait time is 3 to 5 months.

PSYCHIATIRC CONSULTATION

There were five programs in this service sub-category, two of them completed their narrative reports, and both of these were new programs.

Analysis of Impact Objectives (New Programs Only):
Both programs indicated that all major objectives were met, and that survey reports showed that client survey satisfaction was high.

Changes Made in Program (New Programs Only);
For one new program a wait list for psychiatric/ medication evaluation and treatment had to be implemented as a result in the reduction in funding for the program and the reduction of available psychiatrists in the community mental health system.
The other program reported that different support groups were created to reflect changes in client populations, more female and transgender clients. Also an increase in dually diagnosed clients has resulted in changes made to program to accommodate their different and more immediate needs.

Inclusion of Wait Lists (All Programs):
Only one of these two programs utilized a wait list, averaging 4 clients on the list who generally waited about 3 weeks for services.

CRISIS SERVICES

There were two programs in this sub-category and both completed their narrative report, neither [illegible] program.

Inclusion of Wait Lists (All Programs):
Neither of these programs utilized a wait list.

RESIDENTIAL CARE

There were three programs in this sub-category, only one returned a report, it was not a new program.

Inclusion of Wait Lists (All Programs):
A wait list was utilized, it was indicated that 3 to 4 clients are generally on the list and wait an average of two weeks for services.

SUBSTANCE USE SERVICES

LONG TERM RESIDENTIAL

There were three programs in this service sub-category, two completed their reports, neither one was a new program.

Inclusion of Wait Lists (All Programs):
One program stated that while a wait list is utilized for their services in general, those clients who are HIV+ and in need of this type of care are immediately placed in one of their facilities. The other program maintains a wait list, because of the small number of beds available, which has no more than 1 to 3 clients.

SHORT TERM RESIDENTIAL

There were 8 programs in this sub-category, five of them completed their narrative reports, none of these were new programs.

Inclusion of Wait Lists (All Programs):
All five of these programs maintain a wait list of some sort. A few indicated that months of inclement weather greatly increased the numbers on the wait list. However, generally those numbers were between 2 to 9 clients and the average wait was anywhere from a few days to about one month.

METHADONE

There was only one program in this sub-category, which did turn in a report.

Inclusion of Wait Lists (All Programs):
Their wait list typically had about 20 names, and the average time for admission for an HIV+ individual varied between 2 to 4 weeks.

OUTPATIENT SUBSTANCE COUNSELING

There were five listed programs in this sub-category and four of those turned in their narrative reports none of these were new programs.

Inclusion of Wait Lists (All Programs):
None of these programs maintained a wait list. All four indicated that they were able to accommodate all requests for services.

DETOX

There were two programs in this sub-category and both completed their reports, neither one was a new program.

Inclusion of Wait Lists (All Programs):
Both programs maintained a wait list. One stated that there are typically five clients on the list at any given time and that the average wait time is about five days. The other indicated that there is rarely a wait list and that when it occurs it is during peak times such as flu season in the winter. This program generally had clients admitted within 24 to 48 hours.

CASE MANAGEMENT

CASE MANAGEMENT

Of the 31 programs in this sub-category only 5 returned their narrative reports, none of these were for new programs.

Inclusion of Wait Lists (All Programs):
Of the five programs reporting, only two maintained a wait list for case management services. One stated that the average number on the list was five clients who generally waited about two weeks for services. The other program stated that they rarely have any names on their wait list (currently did not) and that the average wait time was about two weeks as well.

PEER ADVOCATE OUTREACH

Of the two programs in this sub-category only one returned their report. It was a new program.

Impact Objectives (New Program Only):
There were no specific impact objectives per se for the peer advocacy program. Objectives were blended in with case management program objectives.

Changes Made in Program (New Program Only):
No significant alterations to the program were made.

Inclusion of Wait Lists (All Programs):
There were currently about 70 clients on this list awaiting access to services, it was not indicated what the typical wait time for services was.

INTEGRATED CASE MANAGEMENT

Of the six programs in this sub-category, three completed their narrative reports, and all were new programs.

Analysis of Impact Objectives (New Programs Only):
One program stated that there were no impact objectives outlined in their contract for that fiscal year. The others demonstrated that their statistical numbers for certain objectives were met. All indicated a high level of client satisfaction from returned surveys.

Changes Made in Program (New Programs Only):
Streamlining of case management and peer advocate responsibilities were cited by one program, the others indicated no major changes to programs.

Inclusion of Wait Lists (All Programs):
No program utilized a wait list.

DAY OR RESPITE CARE

There were four programs in all three of the sub-categories for this service, three of those returned their narrative reports, none of these were new programs.

Inclusion of Wait Lists (All Programs):
Of the three reporting programs, only one utilized a wait list (in Children's Programs and Childcare sub-category), the average reported number on the wait list was 8 and the cited average wait time was 6 months to 1 year.

TRANSPORTATION

There was only returned narrative report for this service category, it was not a new program.

[illegible] of Wait Lists (All Programs):
[illegible] list was used.

CLIENT ADVOCACY

There were nine programs contained within the four service sub-categories listed under Client Advocacy, five of those returned their reports. None of these were new programs.

Inclusion of Wait Lists (All Programs):
Only two utilized a wait list. One program typically had about 20 clients on a wait list, but the names were merely maintained until the next training occurred, generally about one month. The other program (Legal/Immigration Assistance category) generally had fewer than five clients on a wait list ("never more than 10"), with the wait time reported as being under one month.

LEGAL/ GUARDIANSHIP/ CHILDREN

There was only program listed in this category, a narrative report was completed, it was not a new program.

Inclusion of Wait Lists (All Programs):
No wait list was utilized.

SYSTEM WIDE GAPS IN SERVICES:

When system-wide gaps in services were noted, overwhelming the most common gap cited was **housing**, by programs in all service categories. Some of the common points or compelling statements about housing follow:

- Some clients prefer the streets to shelters or Tenderloin SRO's.
- Housing is required to refrigerate meds and to ensure proper nutrition.
- Staying in SRO's often leads to theft of meds, sexual assault and other types of victimization.
- Most critical gap is in emergency housing and rental subsidies (although the Emergency Housing Vouchers and Shallow Rent Subsidy programs have provided significant improvement in ongoing housing crisis.) One specific gap is in providing options for rental subsidy when clients barely miss eligibility requirements for Shallow Rent Subsidy. For multiple-diagnosed clients, the four-week turnaround time is not sufficient to stabilize clients [illegible] organize some structure in their lives and enable them to get into permanent [illegible] leads to [illegible] agency [illegible] because [illegible] are not permanent residents.
- Clients with records of evictions are difficult to place. Managers of SRO's are often unwilling to grant permanent residency to clients, mostly because of low [illegible] the vacancy rates, which virtually guarantees them placement of temporary tenants.

- Availability of Permanent Housing is lacking system wide. Clients at Transitional Housing program usually reside there for 9 months to one year, instead of six months, because of the lack of Permanent Housing.
- Changes in FMR to allow CARE funded subsidies to rise to a true "Fair Market Value" for San Francisco should be made.
- Most lacking is affordable independent housing. Permanent housing residents receiving subsidies often do not use them, because they cannot find affordable housing or housing that will accept their subsidy.
- Housing advocacy to identify cooperative landlords and locate permanent housing would be helpful.

After the many comments regarding housing the other system-wide gaps most commonly mentioned were **substance use and mental health services.** One was rarely mentioned without a reference to the other. Some observations most commonly cited were:

- Lack of contracted substance abuse or mental health services within agency's system (despite the fact that large percentages of clients have active substance abuse issues and are living with active psychiatric issues.)
- Substance abuse management support for people unable to adopt abstinence-based treatment constructs (new models are needed.) Mental health services that are not MD-based, especially long-term therapy are needed.
- Mental health services have long wait list and complicated screening procedures.
- Some people may be eligible for the services, but may be unwilling to abide to the rules of the congregate houses, or may not want the service because of restraints on their preferred lifestyle.
- There are also people who are unable to avail themselves of the services before death from a terminal condition occurs.
- One possible solution for this population falling through the cracks is residential treatment with medical assistance.
- Long term psychotherapy options for clients with needs that cannot be met with the brief therapy model.

A few other noted system-wide gaps that received several mentions were:

- **Harm Reduction Model** needed for clients who are unable or unwilling to stop drug use, yet most drug treatment services require abstinence from clients. Problems cited for drug treatment services included restrictive operating hours, punitive treatment in program, problematic urine screening tests for prescribed medications resulting in protocol violations.
- Transportation is a problem, there are not enough taxi vouchers allocated.
- Administrative Burden of reporting for CARE-funded programs could be lessened by consolidation of some administrative requirements such as narrative statistics.
- Flexibility of funds to provide needed services not in contract as the needs arise would be beneficial to the clients.
- Substance use therapies should include **complimentary therapies**, especially acupuncture as a detox modality for drug dependency withdrawal. Also, provisions for the homebound to continue receiving complementary therapies are needed. The demand for complementary therapies is greater than the supply.

- **Childcare services** are lacking. Current respite services are inadequate to meet the needs.
- High rate of **staff turnover** has greatly impacted provision of services. Turnover is due to high levels of burnout, grieving, overall program concerns.
- **Case management services** are not available at a high enough level to meet the demand.

INVOLVEMENT OF PEOPLE WITH HIV/AIDS:

Nearly all respondents stated the utilization of a **client satisfaction survey** as a means of soliciting suggestions and feed-back from clients for potential inclusion into program development or alterations.

About 20% of those responding indicated an **active program of outreach** to hire HIV+ staff and/or to recruit HIV+ Board members.

Many of the larger agencies incorporated a **community advisory board** to elicit suggestions and contributions from clients and community members. Often this was also done by some of the larger agencies by holding annual or quarterly community meetings.

Most all programs involved in Peer Advocacy went into great detail of the **direct involvement of clients** in that program. A few utilized **client-published newsletters.** Most all of the case management programs reported that **case managers actively solicit input** regarding the program and services from clients at each meeting.

Three separate agencies reported an **open door policy** of their director's that was utilized by clients with suggestions, complaints or general feed-back.

TECHNICAL ASSISTANCE NEEDS:

[illegible] three-quarters of the agencies reporting any technical assistance need[illegible]sted [illegible] technical assistance "[illegible]" [illegible] effectively with REGGIE [illegible] that any [illegible] Y2K problems, or for assistance with general data entry or administrative work that arises due to various reporting requirements. This was clearly one of the most common requests.

Second to that request the most commonly requested technical assistance was **non-specified computer training** for staff.

Other common requests included:

- Increasing skills in program planning and evaluation, evaluation and systemization of internal protocols and procedures, and ongoing staff skills-building in areas related to program implementation for Integrated Services such as harm reduction, basic mental health assessment for non-mental health providers and basic substance abuse assessment.
- Access of staff to medical and nutritional information, especially updates on protocols and treatments.
- Additional social work/case management assistance to help manage the multiple housing and financial problems of clients.
- Submitting of fewer and less redundant reports.
- Technical assistance regarding additional client recruitment and linkage to additional referral sources.
- Assistance in outreach efforts for locating hotels that meet the minimum health and standards and landlords that would be willing to participate in programs either by agreeing to take referrals for emergency housing or by agreeing to take subsidy clients as tenants.
- A streamlined approach to contracting and reporting for DPH contracts, especially during the initial stage of program implementation. Also, a more extended period of evaluation for newer programs.
- An evaluator to conduct a "clinic flow" analysis would be helpful.
- Computer vouchers to increase staff's skills.

ATTCHMENT E

MEMORANDUM

Date: June 25, 1999

To: Members of HIV Health Services Planning Council

Through: Russ Zellers, Assistant Director, DPH, HIV Health Services

From: Dean Goodwin, HIV Health Services

Re: Utilization Report

Attached please find the utilization data that you requested as related to CARE Title I and Title II contracts for FY 98-99. This analysis does not include Title I dollars for Marin and San Mateo counties. State and General Fund contract dollars are also not included in this analysis.

Please note that there have been some changes in the service sub-categories since the last fiscal year; particularly within Health Care, Housing, Substance Use Services and Case Management. This Utilization Report is presented in terms of FY 98-99 Service Categories, therefore these changes must be considered in making any funding changes in FY 99-00 programs.

Please see the attached comparison of FY 98-99 and proposed FY 99-00 Service Sub-categories.

Within the Health Care Service Category, the FY 99-00 Sub-category of Home-based Home Care will contain programs that were defined in FY 98-99 as Home Health and In-Home Respite (Day/Respite/Child Care). Dental Care in FY 98-99 will be split into two categories for FY 99-00, Centralized Dental Services and De-Centralized Dental Services. The FY 99-00 Facility-based Home Care will incorporate the previously defined Residential Hospice (Housing) programs. The new category of Integrated Services of Health Care, created during FY 98-99, is listed separately.

Within Housing, most programs previously defined as Emergency Vouchers (98/99) will fall under Emergency Housing (99/00) and most defined as Permanent Housing (98/99) will fall under Residential Programs and Subsidies (99/00). The Case Management/ Peer Advocacy Outreach Services (98/99) and Housing/ Practical Support by Peer Volunteers (98/99) programs will be merged into Client Advocacy/ Peer Advocacy for FY 99-00. Housing/ Financial Services will be Client Advocacy/ Money Management in FY 99-00.

In Substance Use Services, Long Term Residential (98/99) and Short Term Residential (98/99) programs were merged together into Residential Treatment (99/00)

In Case Management, the new category of Integrated Services of Case Management is listed separately.

Service Sub-categories that will no longer be identified in FY 99-00 include Emotional/Practical Support and Training (Buddy/Companion Category), Food Solicitation (Food), Community Events (Client Advocacy) and Vision Impairment (HealthCare).

Overall, most Service Sub-categories had very high percentages of Unduplicated Clients served and Units of Service delivered. In instances where actual UDC served greatly exceeded the contracted UDC, investigation by program managers was conducted. In some cases explanations included the development of new programs, program closures, problems with staffing vacancies and similar reasons. Comments are noted on the far right column of the accompanying sheet. However, in many of these instances of overproduction it was generally a result of evolving client demographics or emergence of an unmet need that was underestimated in contract negotiations. Also, in some instance agencies cautiously set their UDC goals in order to ensure meeting those goals by the end of the fiscal year, but provided service to a higher number of clients as needed.

The dollar value of vouchers were pulled from the program contract amounts as was the clients numbers related to vouchers, where it was evident.

Please see the notes column on the attached report for comments concerning expenditures or deliverables.

Utilization Report
CARE-I and CARE-II Programs for FY-98/99

Code	Budget Sub-Category	Amount in Contracts	Percent of Contracts Expended	% of U.O.S. Achvd.	% of UDC Achvd.	Rationale for Low Expenditures or Deliverables
	Health Care					
A1	Primary Care	$5,007,166	100%	128%	117%	
A3	Dental	$647,528	83%	84%	151%	Underestimation of client utilization.
A4	Pharmaceutical	$458,011	100%	100%	100%	
A5	Complimentary Therapies	$753,833	99%	88%	103%	
A6	Home Health	$1,183,825	91%	97%	88%	
A7	Integrated Services	$1,972,471	81%	67%	110%	New Programs
	Housing/Subacute Housing					
31	Emergency Vouchers	$1,873,117	96%	80%	129%	Some were new progs, and some uncompleted vouchers were turned over to new clients.
37	Permanent Housing	$3,936,353	98%	104%	127%	Higher rate of turnover of subsidies and clients than expected.
32	Residential Hospice	$1,193,669	100%	108%	100%	One CARE prog. only.
33	Transitional	$305,460	100%	90%	77%	One CARE funded prog only, start-up
34	Support Services/Financial	$306,159	97%	101%	102%	
	Food					
C1	Food Bank/ Delivered Meals	$1,335,090	100%	127%	115%	
C3	Nutrition Counseling	$33,623	89%	89%	201%	1 program, # of clients underestimated adjusted for FY99/00.
C4	Congregate Meals	$34,694	100%	103%	100%	
C5	Food Solicitation	$69,762	100%	149%	N/A	No client information collected
	Mental Health Counseling					
D1	Long/ Short Term Psychotherapy	$2,687,618	97%	104%	126%	Difficult to estimate # of clients for these services
D2	Psychiatric Consultation	$440,757	100%	136%	196%	Some new programs
D3	Crisis Services	$436,456	100%	113%	110%	
D4	Residential Care	$716,302	98%	109%	91%	
	Substance Services					
E1	Long Term Residential	$788,150	100%	101%	211%	More clients/ quicker turnover anticipated& one prog. Closed.
	[illegible] Term Residential	$2,928,363	99%	96%	130%	Mid-year prog closure
	[illegible]	$360,597	100%	109%	161%	Increase in Medi-Cal onsite [illegible] session changed level of slot turn-over
E4	Outpatient Substance Counseling	$562,532	87%	91%	129%	Mid-year prog closure
E5	Detox	$550,714	97%	94%	100%	
	Case Management					
1	Case Management	$1,675,963	97%	89%	151%	Changing client demographics difficult to predict.
2	Peer Advocate Outreach	$24,264	78%	39%	161%	Service Catg Changed in FY99/00
7	Integrated Case Mangement	$502,013	89%	86%	83%	New Programs

Utilization Report
CARE-I and CARE-II Programs for FY-98/99

Code	Budget Sub-Category	Amount in Contracts	Percent of Contracts Expended	% of U.O.S. Achvd.	% of UDC Achvd.	Rationale for Low Expenditure or Deliverables
	Client Advocacy					
N1	Benefits Counseling	$239,288	100%	113%	88%	Units were increased for 99/00 contract
N2	Legal/ Immigrant Assistance	$278,820	100%	150%	236%	Adjustments for 99/00 contracts.
N4	Treatment/ Clinical Trials Advcy.	$108,007	98%	72%	81%	
N5	Community Events	$5,766	74%	0%	0%	One prog. only, defunded.
N7	Money Management	$392,753	100%	116%	108%	
	Buddy/ Companion					
K1	Emotional/ Practical Support	$218,461	92%	90%	156%	Service Catg. chngd in FY99/00
	Adoption/ Foster Care					
P1	Legal/Guardianship/Children	$190,915	98%	93%	120%	One program only.
	Day or Respite Care					
J1	Adult Day	$175,740	100%	103%	363%	Overly successful outreach efforts in on large program.
J2	In-Home Respite	$39,485	100%	101%	30%	1 CARE Prog only.
J3	Children's Programs & Childcare	$299,731	97%	100%	112%	
	Planning Council Support					
M2	Planning Council Support	$230,947	56%	100%	N/A	
	Program Support					
Q2	REGGIE/ ACE	$251,035	84%	101%	116%	
	Transportation					
L1	Transportation	$81,871	100%	139%	94%	

Utilization Report
CARE-I and CARE-II Programs for FY-98/99

NOTE: Dollar Amount of vouchers not included. Some UDC counts may reflect voucher clients, which could not be isolated.

(Percent of UOS and UDC were not truncated at 100%. In Range for UOS and UDC was defined as between 90% and 110%.)

Budget Sub-Category #	Budget Sub-Category	Amount in Contracts	Total Amount Expended	Percent of Contracts Expended	Variance: Contract Amt to Amt Expended	U.O.S. Projtd	U.O.S. Achvd	% of U.O.S. Achvd	Projctd Average Cost U.O.S.	Actual Average Cost U.O.S.	UDC Projctd	UDC Achvd	% of UDC Achvd	Projctd Average Cost UDC	Actual Average Cost UDC	Number of Programs	Range of U.O.S. in Prgms	Range of UDC in Prgms	Comments
	Health Care																		
A1	Primary Care	$5,007,166	$4,984,319	99.5%	($22,847)	48,249	61,555	128%	$103.78	$80.97	5,313	6,227	117%	$942.44	$800.44	22	8 In/ 12 Over/ 2 Under	8 In/ 12 Over/ 2 Under	
A3	Dental	$647,528	$538,978	83.2%	($108,550)	6,744	5,667	84%	$96.02	$95.11	845	1,278	151%	$766.31	$421.74	3	2 In Range/ 1 Under	2 Over Range/ 1 Under	Underestimation of client utilization.
A4	Pharmaceutical	$458,011	$458,011	100.0%	$0	10,279	10,279	100%	$44.56	$44.56	843	843	100%	$543.31	$543.31	1	In Range.	In Range	
A5	Complimentary Therapies	$753,833	$743,258	98.6%	($10,575)	12,820	11,219	88%	$58.80	$66.25	665	685	103%	$1,133.58	$1,085.05	5	3 In/ 1 Over/ 1 Under	3 In/ 1 Over/ 1 Under	
A6	Home Health	$1,183,825	$1,074,955	90.8%	($108,870)	37,042	35,872	97%	$31.96	$29.97	352	310	88%	$3,363.14	$3,467.60	6	2 In/ I Over/ 3 Under	2 In/ I Over/ 3 Under	
A7	Integrated Services	$1,972,471	$1,599,494	81.1%	($372,977)	33,455	22,480	67%	$58.96	$71.15	962	1,055	110%	$2,050.39	$1,516.11	11	2 In/ 1 Over/ 8 Under	2 In/ 3 Over/ 6 Over	New Programs
	Housing/Subacute Housing																		
B1	Emergency Vouchers	$1,873,117	$1,801,158	96.2%	($71,959)	19,266	15,370	80%	$97.22	$117.19	2,950	3,817	129%	$634.95	$471.88	5	2 In Range/ 3 Under	3 Over Range/ 2 Under	Some were new progs, and some uncompleted vouchers were turned over to new clients.
B7	Permanent Housing	$3,936,353	$3,839,745	97.5%	($96,608)	222,710	232,435	104%	$17.67	$16.52	1,326	1,686	127%	$2,968.59	$2,277.43	11	All In Range	7 In Range/ 4 Over	Higher rate of turnover of subsidies and clients than expected.
B2	Residential Hospice	$1,193,669	$1,193,669	100.0%	$0	7,787	8,376	108%	$153.29	$142.51	66	66	100%	$18,085.89	$18,085.89	1	In Range	In Range	One CARE prog. only.
B3	Transitional	$305,460	$305,449	100.0%	($11)	2,699	2,417	90%	$113.18	$126.38	30	23	77%	$10,182.00	$13,280.39	1	In Range	Under Range	One CARE funded prog only, start-up
B4	Support Services/Financial	$306,159	$297,397	97.1%	($8,762)	10,455	10,531	101%	$29.28	$28.24	347	354	102%	$882.30	$840.10	5	4 In Range/ 1 Over	2 In/ 2 Over/ 1 Under	
	Food																		
C1	Food Bank/ Delivered Meals	$1,335,090	$1,335,090	100.0%	$0	231,744	293,296	127%	$5.76	$4.55	1,204	1,390	115%	$1,108.88	$960.50	3	2 In Range/ 1 Over	1 In Range/ 2 Over	
C3	Nutrition Counseling	$33,623	$29,926	89.0%	($3,697)	468	418	89%	$71.84	$71.59	100	201	201%	$336.23	$148.89	1	In Range	Over Range	1 program, # of clients underestimated, adjusted for FY99/00.
C4	Congregate Meals	$34,694	$34,694	100.0%	$0	6,870	7,065	103%	$5.05	$4.91	90	90	100%	$385.49	$385.49	1	In Range	In Range	
C5	Food Solicitation	$69,762	$69,762	100.0%	$0	410,365	610,119	149%	$0.17	$0.11	0	0	N/A	N/A	N/A	1	Over Range	N/A	No client information collected.
	Mental Health Counseling																		
D1	Long/ Short Term Psychthrpy	$2,687,618	$2,606,618	97.0%	($81,000)	34,948	36,267	104%	$76.90	$71.87	1,753	2,206	126%	$1,533.15	$1,181.60	15	9 In/ 2 Over/ 4 Under	6 In/ 7 Over/ 2 Under	Difficult to estimate # of clients for these services.
D2	Psychiatric Consultation	$440,757	$440,757	100.0%	$0	5,113	6,931	136%	$86.20	$63.60	434	852	196%	$1,015.57	$517.32	5	1 In/ 3 Over/ 1 Under	All Over Range	Some new programs
D3	Crisis Services	$436,456	$436,456	100.0%	$0	7,781	8,771	113%	$56.09	$49.76	2,651	2,907	110%	$164.64	$150.14	2	1 In Range/ 1 Over	1 In Range/ 1 Over	
D4	Residential Care	$716,302	$703,857	98.3%	($12,445)	5,942	6,485	109%	$120.55	$108.54	86	78	91%	$8,329.09	$9,023.81	3	1 In/ 1 Over/ 1 Under	1 In/ 1 Over/ 1 Under	

Utilization Report
CARE-I and CARE-II Programs for FY-98/99

NOTE: Dollar Amount of vouchers not included.
Some UDC counts may reflect voucher clients, which could not be isolated.

(Percent of UOS and UDC were not truncated at 100%. In Range for UOS and UDC was defined as between 90% and 110%.)

Code	Budget Sub-Category	Amount in Contracts	Total Amount Expended	Percent of Contracts Expended	Variance Contract Amt. to Amt. Expended	U.O.S. Projtd.	U.O.S. Achvd.	% of U.O.S. Achvd.	Projctd. Average Cost U.O.S.	Actual Average Cost U.O.S.	UDC Projctd.	UDC Achvd.	% of UDC Achvd.	Projctd Average Cost UDC	Actual Average Cost UDC	Number of Programs	Range of U.O.S. in Prgms.	Range of UDC in Prgms.	Comments
	Substance Services																		
E1	Long Term Residential	$786,150	$786,150	100.0%	$0	11,330	11,465	101%	$69.39	$68.57	109	230	211%	$7,212.39	$3,418.04	3	2 In Range/ 1 Under	3 Over Range	More clients/ quicker turnover than anticipated& one prog Closure.
E2	Short Term Residential	$2,928,363	$2,912,732	99.5%	($15,631)	36,065	34,665	96%	$81.20	$84.03	503	652	130%	$5,821.80	$4,467.38	8	6 In Range/ 2 Under	2 In/ 5 Over/ 1 Under	Mid-year prog closure
E3	Methadone	$360,597	$360,597	100.0%	$0	4,228	4,621	109%	$85.29	$78.03	150	241	161%	$2,403.98	$1,496.25	1	In Range	Over Range	Increase in Medi-Cal cnslg minutes per session, changed level of service & high slot turn over.
E4	Outpatient Substance Coun	$562,532	$488,912	86.9%	($73,620)	9,711	8,871	91%	$57.93	$55.11	376	484	129%	$1,496.10	$1,010.15	5	1 In/ 2 Over/ 2 Under	4 Over Range/ 1 Under	Mid-year prog closure
E5	Detox	$550,714	$532,894	96.8%	($17,820)	6,437	6,073	94%	$85.55	$87.75	320	321	100%	$1,720.98	$1,660.11	2	1 In Range/ 1 Under	1 Over/ 1 Under	
	Case Management																		
I1	Case Management	$1,675,963	$1,630,722	97.3%	($45,241)	58,033	51,401	89%	$28.88	$31.73	2,138	3,238	151%	$783.89	$503.62	31	14 In/ 9 Over/ 8 Under	5 In/ 22 Over/ 4 Under	Changing client demographics difficult to predict.
I2	Peer Advocate Outreach	$24,264	$18,884	77.8%	($5,380)	677	263	39%	$35.84	$71.80	71	114	161%	$341.75	$165.65	2	All In Range	1 Over Range/1 Under	Service Catg. Changed in FY99/00
I7	Integrated Case Mangement	$502,013	$448,245	89.3%	($53,768)	10,006	8,592	86%	$50.17	$52.17	431	359	83%	$1,164.76	$1,248.59	6	1 In/ 2 Over/ 3 Under	2 In/2 Over/ 2 Under	New Programs
	Client Advocacy																		
N1	Benefits Counseling	$239,288	$239,288	100.0%	$0	5,108	5,797	113%	$46.85	$41.28	948	832	88%	$252.41	$287.61	2	Both Over Range	1 Over Range/ 1 Under	Units were increased for 99/00 contracts
N2	Legal/ Immigrant Assistance	$278,820	$277,649	99.6%	($1,171)	5,048	7,567	150%	$55.23	$36.69	888	2,093	236%	$313.99	$132.66	2	Both Over Range	1 In Range/ 1 Over	Adjustments for 99/00 contracts.
N4	Treatmnt/ Clinical Trials Adv	$108,007	$105,572	97.7%	($2,435)	405	293	72%	$266.68	$360.62	189	154	81%	$571.47	$685.53	2	1 In Range/ 1 Under	Both Under Range	
N5	Community Events	$5,766	$4,279	74.2%	($1,487)	710	0	0%	$8.12	N/A	384	0	0%	$15.02	N/A	1	Under Range	Under Range	One prog. only, defunded.
N7	Money Management	$392,753	$392,749	100.0%	($4)	16,666	19,303	116%	$23.57	$20.35	800	863	108%	$490.94	$455.10	2	1 In Range/ 1 Over	Both In Range	
	Buddy/ Companion																		
K1	Emotional/ Practical Support	$218,461	$200,124	91.6%	($18,337)	3,012	2,713	90%	$72.53	$73.78	175	273	156%	$1,248.35	$733.05	7	2 In/ 2 Over/ 3 Under	3 Over Range/ 4 Under	Service Catg. chngd in FY99/00
	Adoption/ Foster Care																		
P1	Legal/Guardianship/Children	$190,915	$187,593	98.3%	($3,322)	3,408	3,176	93%	$56.02	$59.07	50	60	120%	$3,818.30	$3,126.55	1	In Range	Over Range	One program only

Utilization Report
CARE-I and CARE-II Programs for FY-98/99

NOTE: Dollar Amount of vouchers not included.
Some UDC counts may reflect voucher clients,
which could not be isolated.

[Percent of UOS and UDC were not truncated at 100%. In Range for UOS and UDC was defined as between 90% and 110%.]

Sub-Category	Budget Sub-Category	Amount in Contracts	Total Amount Expended	Percent of Contracts Expended	Variance: Contract Amt to Amt Expended	U.O.S. Projtd.	U.O.S. Achvd.	% of U.O.S. Achvd	Projctd. Average Cost U.O.S.	Actual Average Cost U.O.S.	UDC Projctd.	UDC Achvd.	% of UDC Achvd.	Projctd. Average Cost UDC	Actual Average Cost UDC	# of Programs	Range of U.O.S. in Prgms	Range of UDC in Prgms	Comments
	Day or Respite Care																		
J1	Adult Day	$175,740	$175,740	100.0%	$0	2,808	2,890	103%	$62.59	$60.81	27	98	363%	$6,508.89	$1,793.27	1	In Range	Over Range	Overly successful outreach efforts in one large program.
J2	In-Home Respite	$39,485	$39,485	100.0%	$0	2,880	2,917	101%	$13.71	$13.54	10	3	30%	$3,948.50	$13,161.67	1	In Range	Under Range	1 CARE Prog only.
J3	Children's Progms & Childca	$299,731	$291,877	97.4%	($7,854)	20,788	20,701	100%	$14.42	$14.10	75	84	112%	$3,996.41	$3,474.73	2	Both In Range	1 In Range/ 1 Over	
	Planning Council Support																		
M2	Planning Council Support	$230,947	$129,001	55.9%	($101,946)	3,805	3,805	100%	$60.70	$33.90	N/A	N/A	N/A	N/A	N/A	1	In Range	Over Range	
	Program Support																		
Q2	REGGIE/ ACE	$251,035	$211,122	84.1%	($39,913)	1,114	1,127	101%	$225.35	$187.33	129	149	116%	$1,946.01	$1,416.93	3	All In Range	2 In Range/ 1 Over	
	Transportation																		
L1	Transportation	$81,871	$81,871	100.0%	$0	6,345	8,830	139%	$12.90	$9.27	544	510	94%	$150.50	$160.53	2	Both Over Range	1 In Range/ 1 Over	

ATTACHMENT F

ATTACHMENT F

City and County of San Francisco | Department of Public Health

MEMORANDUM

TO: HIV Health Service Planning Council

FROM: Russ Zellers

DATE: July 22, 1999

SUBJ: Linkage of Substance Use and Outpatient Mental Health Services with Networks of Care

The Mental Health prioritization work group has requested an update on the linkage of outpatient Mental Health services with networks of care such as Integrated Service Programs. As you may remember, the HIV Health Services section organized a community meeting on March 25, 1999, bringing together outpatient mental health, substance use, and Integrated Service Programs (ISP). Two of the six ISPs did not attend and a third program was represented only during the first segment of the meeting. Approximately 8 possible new linkages were identified at the meeting including the following:

- 3 new linkages between substance use and primary care programs
- 4 new linkages between mental health and ISPs
- 1 new linkage between an ISP agency that also offers substance use services with other ISPs

The substance use linkages have resulted in strengthened referral relationships among those providers but, to our knowledge, no out-stationing of staff at primary care or ISP sites has developed. One of our outpatient substance use programs already provides on-site assessment and counseling for women. One of the ISP's that also provides substance use services has prioritized ISP and other primary care clients for enrollment and has developed and distributed a special referral form for this purpose.

With regard to new linkages between outpatient mental health and ISPs, there have been discussions between two mental health programs and three ISPs [SFCCC/Urban Indian Health/NAAP, WIDS (Lyon Martin Health Clinic), and the Living Well Project] about new arrangements for providing services to ISP clients. Several Letters of Cooperation have been signed between agencies, including one with NAAP that was not proposed at our March 25th meeting. To our knowledge, none of these have yet materialized into a changed service arrangement involving on-site mental health services for ISP clients. Space was a problem for one proposed collaboration. Two agreements are planned to be implemented by the end of the calendar year but the details of these agreements have not yet been finalized. There have been

discussions among agencies about trying to expand on-site mental health services to ISP as well as other community-based primary care sites but funding is an obstacle. **In this instance, the process of requesting voluntary program collaborations without offering additional funding is not viewed by our office as a successful method for bringing about substantial change in the system of care.**

However, the information presented here should be interpreted in a broader context. Many of the outpatient mental health providers have pre-existing and long-standing cooperative arrangements with other providers. Some of the CARE contract exhibits funded in this sub-category provide extensive consultation, assessment, treatment, and crisis services on-site at community and hospital based programs throughout the City. Therefore, the March 25th meeting was an attempt to ask providers to extend themselves even further into the community without additional resources.

HIV Health Services is planning to meet with the Integrated Service Programs over the next few months to assess the exact type and amount of substance use and mental health services that are needed by each program.

ATTACHMENT G

PG	TAL	STORY SLUG	?	GRAPHIC	VIS	VTR	TIME	B/T	WRI
19		PRISON INMATES	R		990711	SOT--PKG	1:50		cea

MODIFIED: Mon Jul 19 16:35 1999 BY: prosser ARCHIVE: 3428

A NEW GOVERNMENT STUDY OF THE GROWING POPULATIONS OF THE NATION'S PRISONS AND JAILS... INDICATES THE FACILITIES ARE USED MORE AND MORE TO WAREHOUSE THE MENTALLY ILL.

JONATHAN KARL REPORTS.

TR/SOT PKGF --->>> <<=== SOT PKG ===>>
<<=== SOT PKG ===>>

CG 2LINE
aurie Flynn
ental Health Activist

CG 2line
llen Beck
.S. Justice Department

CG 2line
ancy Mahon
oros Foundation

CG rpt
onathan Karl
n Washington, D.C.

Prisons and jails now house more mentally ill people than hospitals or treatment centers. A first-ever study on the problem by the Justice Department found there are now nearly 300,000 mentally ill people behind bars: "PEOPLE WITH MENTAL ILLNESS USED TO BE TREATED IN HOSPITAL AND HEALTH FACILITIES ARE NOW BEING CRIMINALIZED, BEING ARRESTED, INCARCERATED AT RECORD RATES." There are now 283,000 mentally ill people in jails and prisons, representing about 15-percent of the total. There are another 547,800 on parole. More than half of mentally ill are incarcerated for violent crimes, including: - murder - rape - assault "ON ALMOST EVERY MEASURE WE LOOK AT, IN TERMS OF THEIR CRIMINAL RECORD, IN TERMS OF THEIR CURRENT OFFENSES, IN TERMS OF THE ACTS UNDER SUPERVISION, THERE'S A HIGHER PREVELANCE OF VIOLENCE BY THOSE LISTED AS MENTALLY ILL." The survey found that 60-percent have received some form of treatment, but advocates for the mentally ill say treatment at prisons is grossly inadequate: "IT'S A VERY REGIMENTED ATMOSPHERE WHERE MOST MENTALLY ILL PEOPLE DON'T DO VERY WELL, AND THEN THESE PEOPLE ARE ESSENTIALLY DUMPED ONTO THE STREETS, IN WORSE SHAPE THAN THEY WERE WHEN THEY ENTERED THE SYSTEM." Mental health advocates say the survey shows prison is a costly and ineffective place to deal with the mentally ill. They say resources should be redirected from incarceration to treatment. The lack of treatment has social costs as most of the mentally ill commit crimes again after being released from prison. In fact, more than half of the mentally ill inmates in the Justice Department survey had been sentenced to prison on at least three seperate occasions. Jonathan Karl, Washington.

HIV HEALTH SERVICES PLANNING COUNCIL
Prioritization 2000-2001

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August 2, 1999 4:30 - 7:30 PM

25 Van Ness Ave., Room 330-A

Agenda

I.	Last Year's Implementation Plan Michelle Long Dixon & Russ Zellers	4:30 PM
II.	URS Data Russ Zellers & Michelle Long Dixon	4:50 PM
III.	Marin & San Mateo Counties John Conley & Kelly Wallace	5:00 PM
IV.	Peer Advocacy/Practical Support/Home Health Kirsten Balano, Tom Calvanese & Nilda Rodriguez	5:15 PM
V.	Peer Support/Community Center Don Bliss, Tom Calvanese & Luis De La Torre	5:35 PM
VI.	COLAS Mary Jane Wood & Kelly Wallace	5:55 PM
BREAK		6:00 PM
VII.	Review Overview/Consensus document - VOTE	6:15 PM
VIII.	Mental Health - Vote Mary Jane Wood, Don Bliss & Laura Guzmán	6:35 PM
IX.	Other Service Category (ies)	6:55 PM
X.	Review work plan for next meeting	7:20 PM
XI.	Adjourn	7:30 PM

SF Dept. of Public Health — AIDS Office, 25 Van Ness; City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

The sites are fully accessible and assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to the Council Members, are available for inspection and copying. For further information, call the Council's staff 415-554-9136. The closest accessible BART Station is Civic Center. Accessible MUNIlines serving these location are: #42 Downtown Loop, #71 Haight/Noriega, #9 San Bruno, F Line to Market and Van Ness, and Metro Van Ness station. For more information about MUNI accessible services call 923-6142. *Minutes of Meetings are tentative until formally approved by the Council*

HIV HEALTH SERVICES PLANNING COUNCIL

August 2, 1999

The Minutes of this meeting are missing.

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HIV HEALTH SERVICES PLANNING COUNCIL

August 9, 1999

The Agenda of this meeting is missing.

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Minutes, August 9, 1999 HIV Health Services Planning Council

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I. **Call to Order**
4:30 PM

II. **Roll Call**
Attachment A, Column 1

III. **Review and approval of Agenda**
Agenda accepted.

IV. **General Announcements**
- *SJ* spoke about the need to strategize immediately after Prioritization in anticipation of funding cuts.
- *MS* announced upcoming programs at the Asian-Pacific Islands Wellness Center.
- *Robert Samson* distributed the mailing list for the members to update.
- *DJ* announced a position opening at the Harm Reduction Coalition.

V. **Public Comment**
There was no public comment.

VI. **Mayor's Liaison Report**
Bill Barnes submitted a written report. [Attachment B]

VII. **PWA Caucus Report**
TL recommended hiring *Richard Bargetto* as the new Consumer Rights Activist. He presented his qualifications and asked for a vote.
He discussed the Community Forums as opportunities to provide information on Prioritization and to get community response. He recommended doing five, in Bayview, Western Addition, Tenderloin, Castro and the Mission.
He discussed the Open Hand Letter. Despite *Jim Illig's* presentation explaining their Board of Director's decision, the PWA felt the six month re-certification was excessive for those who were most vulnerable, and recommended sending a letter to Open Hand expressing their concerns.
Drop-In Centers. An ad hoc committee had already been formed to study the issue.
Under Case Management he stressed the need for clarification and training, as well as use of existing protocols. [Attachment C]
DJ provided some history about the former activist, *Toni Young*. She emphasized that *Richard Bargetto* would be accountable to the Steering Committee, and would be working with the PWA Caucus. *AM* asked if funds were available to pay his salary. *TC* responded affirmatively, for the present time. *MS* expressed support for *Bargetto* specifically because he was not from San Francisco, adding that he would have to be brought up to speed.
VOTE: The motion to hire Richard Bargetto passed. [2]
LO'C announced the forums for October, January, February, March and April. *SJ* and *VC* volunteered to assist with the first forum in Bayview.

VIII. **Membership Committee Report**
LG announced that the council was currently full, and that although they would continue to accept applications they could not accept anyone else. She spoke of the need to attract a Title IV representative, transgender, women (currently the council is 30/50 women to men), and individuals recently released from prison. She requested a vote on those incumbents whose terms

had expired who were seeking another term (*JB, DB, VC, TL, AM, LAM, NN, LO'C, LO, SO, MS*). She did not recommend *LAM* as a member in good standing. *DJ* responded that since *LAM* had not requested another term there was no vote needed on her.

VOTE: The motion to approve the afore-mentioned incumbents for re-appointment passed. [3]

She announced the following incumbents up for re-appointment in September: *TC, BC, JC, SJ, DJ, JO, AR, SS, and EW.*

She also proposed a buddy system for pairing new members with existing ones. *MS* brought up the issue of not having a member of the Health Commission on the council. *DJ* responded that *LAM* was the third member of the Health Commission who was unable to meet the minimum attendance requirements. There had been a proposal to have a liaison with the Commission who would meet with the council on a quarterly basis. Although that proposal had previously not been accepted, she said it was back on the table.

IX. **HIV Health Services Report – AIDS Office**

Laura Thomas passed around a memo on the percentage of Title I CARE funding for women and children. [Attachment D] Based on current spending levels, no significant changes in services were necessary. She also passed out representative information forms that were needed to fill out the grant application, which was due on September 30th. She said it would be available for review by the members the week of September 20th, and asked if anyone cared to help with the writing process. She continued by saying that the DPH was planning for reductions in CARE funding, and read a series of questions that would be addressed. *LO'C* spoke about the harm in rolling over money. *Laura* responded that it was indeed hard to advocate for SF when money was left unspent each year. *LG* talked about other possible mechanisms for spending the money. *TC* talked about the council's concern with unspent money in the face of unmet need during the course of the year. *DB* talked about other councils having ways of managing money with the grantees to avoid rollovers. *TC* stressed the importance of quarterly reports from the AO about how money was being spent. *Laura* agreed to convey the message.

X. **Prioritization**

DJ distributed and clarified Prioritization 2000-2001 Overview (Attachment E) and Prioritization Ranking (Attachment F). She explained the HRSA requirements around Prioritization and what had been done towards that end (Needs Assessment, Work Groups). The mandate was to elaborate possible scenarios for reduction of funds.

Discussion of Attachment E

DB asked whether integration of services included the horizontal model. *MS* discussed the political sensitivity of such terms as "harm reduction" and "integration of funding streams." He talked about how consolidating contracts had not necessarily worked. *DJ* addressed *MS's* concerns in explaining that "harm reduction" was for internal use only, and that the DPH would handle the language so it did not jeopardize funding. She went on to say that they were not taking a position on how things were to be implemented, but that the DPH had to address the issue of integration of services. *DB* felt the language did not acknowledge both types of integration. He proposed a change in language. *KB* recommended a statement attached to the beginning of the document after FY 2000-01 "...and should be integrated into the contracting process regardless of increased or decreased available funds." to make it more directive. *TC* said that vertical and horizontal integration were not mutually exclusive, and that the system needed to respond to the needs of clients first. *DB* responded in saying that there were times when clients wanted to go to different sites. He proposed changing the final statement in Integration of Services to read "Consolidation of provider contracts and locally based integration of funding streams. " *MS* questioned the efficacy of consolidating contracts. *SS* felt there was a need for some precise

language about directing the DPH to establish better contracting structures. *SJ* questioned the advisability of recreating Prioritization.
GG proposed changing "greatest" to "significant" under Housing.
VOTE: The amendment failed. [4]
LG proposed an amendment to Category #1 to read "Maximizing eligibility of clients to public, cash and health insurance benefits."
VOTE: The amendment passed by acclamation.
KW recommended adding "in co-ordination with other health outreach efforts." to the first statement under Outreach/Education.
VOTE: The amendment passed by acclamation.
DB proposed striking the words "at single site" from the statement beginning "Multiple services" under Integration of Services.
VOTE: The amendment passed by acclamation.
KB proposed striking the entire statement beginning "Consolidation of contracts" and refining it in committee.
VOTE: The amendment passed by acclamation.
VOTE: Attachment E accepted as amended by acclamation.

Discussion of Attachment F
DB requested a list of all HRSA categories. *Laura Thomas* read the list.
KB proposed changing "substance abuse" to "substance use."
VOTE: The amendment passed by acclamation.
VOTE: Attachment F accepted as amended by acclamation.

XI. **New Business**
There was no new business.

XII. **Adjournment**
7:30 PM

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HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

8/9/99		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Alliena Baker	*AB*	A											
Kirsten Balano	*KB*	P	Y	Y	N								
Hazel Betsey	*HB*	P	Y	Y	B								
Donald Bliss	*DCB*	P	B	B	B								
Chris Boehm	*CB*	A											
Jeff Byers	*JB*	P	Y	B	N								
Tom Calvanese	*TC*	P	Y	Y	N								
Bart Casimir	*BC*	A											
Veronika Cauley	*VC*	P	Y	Y	N								
Julie Charubusapayon	*JAC*	P	Y	Y	N								
Raymond Combs	*RC*	A											
John Conley	*JC*	A											
Luis De La Torre	*LDT*	P	Y	Y	B								
Mark Dunlop	*MD*	A											
Gregory Edwards	*GE*	A											
Gene Gowdey	*GG*	P	B	Y	Y								
Laura C. Guzman	*LCG*	P	Y	Y	N								
Siddiq Jihad	*SJ*	P	B	Y	N								
Darrell Joe	*DCJ*	A											
Diane Jones	*DJ*	P	Y	Y	N								
Sam Kaplan	*SK*	P	Y	Y	N								
Tony Leone	*TL*	P	Y	Y	N								
Gene London	*GL*	P	Y	Y	N								
Allen Meyer	*AM*	P	Y	Y	N								
Jim Mitulski	*JM*	P	Y	Y	N								
Lee Ann Monfredini	*LM*	A											
Norm Nickens	*NN*	P	B	Y	N								
Lisa O'Connor	*LO'C*	P	Y	Y	N								
Loras Ojeda	*LO*	A											
Jorge Ortiz	*JO*	P		Y	N								
Stephan Oxendine	*SO*	P	B	Y	N								
Ken Pearce	*KP*	P	B	Y	N								
Alissa Riker	*AR*	P	Y	Y	N								
Nilda Rodriguez	*NR*	A											
Matthew Sharp	*MS*	P	Y	Y	N								
Susan Shea	*SS*	P	Y	Y	B								
Mike Shriver	*MDS*	P	Y	Y	N								
Al Terrazas	*AT*	P	Y	Y	Y								
Kelly Wallace	*KW*	P	Y	Y	Y								
Eric Whitney	*EW*	P	Y	Y	N								
Mary Jane Wood	*MJW*	P	Y	Y	Y								

(Attach. #B)

OFFICE OF THE MAYOR
SAN FRANCISCO

WILLIE LEWIS BROWN, JR.

REPORT TO THE SAN FRANCISCO HIV HEALTH SERVICES PLANNING COUNCIL

Bill Barnes, Advisor to the Mayor on AIDS and HIV Policy
August 9, 1999

CARE COUNCIL APPOINTMENTS

On July 28, 1999, Mayor Brown acted on appointments to the Planning Council. A more detailed memorandum has been circulated to Council Members and can be requested by calling Bill Bourdon at (415) 554-5967.

MAYOR'S OFFICE ORIENTATION FOR NEW COUNCILMEMBERS

The Mayor's Office hosted an orientation to appointed service on August 5, 1999. The orientation was attended by all but two new appointees. Information was provided on conflict of interest and other laws governing the conduct of public officials, the role that appointees play in regard to the Brown administration and overviews of non-CARE funded services provided in the City and County of San Francisco. Norma Thompson, Chris Harris and Aaron Krasnow provided an excellent overview of Housing Opportunities for People with AIDS (HOPWA) programs administered by the Redevelopment Agency. Laura Thomas provided clear, concise and useful information on the overall response of the Department of Public Health in addition to the specific duties of the Planning Council and council members.

Ernest Hopkins also presented on Ryan White CARE Act reauthorization and its importance to sustaining San Francisco's model of HIV care. The Mayor's Office intends to host orientations for new council members as future appointments are made.

STATE BUDGET UPDATE

As you recall, my last report included substantial information on the progress made with regard to the state budget. To recap, the following programs were funded:

$1.825 million for early intervention programs (EIPs);
$1.0 million for Residential Care Facilities for the Chronically Ill (RCFCIs);
$6.0 million for prevention education ($3.0 million targeted at communities of color and women and $3.0 million for high risk men who have sex with men and high risk youth);
$2.0M for prevention evaluation/behavioral surveillance; and
$2.6 million for HIV/AIDS prevention and care services for communities of color.

In addition, $1 million was provided for research on organ transplants for persons with HIV and AIDS, and $2 million for the Universitywide AIDS Research Program. These increases come as a direct result from advocacy from the California HIV Advocacy Coalition.

The statewide planning group will be meeting on the 18th and 19th to discuss the priorities for disbursing the funds. Sources at the Department of Health Services indicate that most of the resources will go through local health departments, instead of directly to community-based organizations, with the rationale that increased coordination will result.

Hepatitis C Hearing

The Board of Supervisors Public Health and Environment Committee will hold a hearing on the impact of Hepatitis C on Thursday, August 12th at 1:00 PM in Room 263 of City Hall. The hearing, called by Supervisor Newsom, is to discuss a resolution directing the Department of Public Health to develop a plan of action to expand and coordinate efforts for Hepatitis C prevention, education, and testing. If the resolution is approved, DPH would have 90 days to report back to the Board on its activities.

Additional Issues

Planning Council members and members of the public are invited to call me to discuss additional issues at (415) 554-5101. From August 11th to 22nd, I'll be unavailable; please contact Bill Bourdon at (415) 554-5967.

(Attach. C)

CASE MANAGEMENT COORDINATION

There is some question as to whether the present HIV care system provides the most effective delivery of case management services. Multiple case management exists, and to some degree, it may even be necessary. However, a lack of coordination among case management service providers can lead to redundancy of services, the creation of more stress on clients, and less than optimal use of shrinking Ryan White dollars. Therefore, the following recommendations are put forward:

- The position of "case manager" needs to be narrowly defined and applied. It appears that the term "case manager" is applied to persons who are neither funded under the case management category nor performing the functions of a case manager. Current programs should be surveyed to determine the number and function of case managers funded outside of case management programs.

- An assessment should be conducted to determine:
1. how many case managers an individual client has,
2. whether the use of multiple case managers is appropriate (contractually driven, need based, or programmatically mandated),
3. which programs mandate case management in order to receive other services, and
4. how case managers are trained and a review of qualifications to do case management.

- An investigation into the feasibility of clients designating a primary case manager should be undertaken. Factors such as disparate caseload (everyone wants to have the most effective case managers). and perceived/actual duress by providers on clients' decision-making regarding a primary case manager should be considered. Data should be collected by surveying clients, case managers and program administrators regarding systemic coordination. Client focus groups should also be conducted.

(Attach B)

City and County of San Francisco | Department of Public Health

MEMORANDUM

TO: HIV Health Services Planning Council

CC: Michelle Dixon
Herman Levias

FROM: Laura Thomas
AIDS Office

DATE: August 6, 1999

RE: Percentage of funding for women and children

According to the Ryan White CARE Act, each Eligible Metropolitan Area (EMA) must ensure that the percentage of Title I funds spent on services for women, children, and infants is not less than their percentage of the EMA's living AIDS cases. For the purposes of the grant application, I need to document that this is the case in San Francisco. The percentage of CARE Title I funds spent on women and children is **18.5%**, well over the mandated threshold of **6%**. The Council does not need to make any service changes based on this information this year.

The percent of living cases which are women, children, and infants for the San Francisco EMA, according to the Centers for Disease Control & Prevention, is 6%. This is for the time period of 7/1/89 to 6/30/99. San Francisco continues to have the lowest percentage of cases in women and children of all of the Title I EMAs.

The percent of Ryan White Title I dollars for the San Francisco EMA spent on services for women is 18.5%. That figure is from the Annual Administrative Report (AAR) for the most recent complete year of CARE services (1998). It includes services in San Mateo and Marin as well as San Francisco. It includes services which are specifically targeted to women, such as primary care, drug treatment programs, or child care, and programs which are not specific to women, but provide services to them. It does **not** include the number of children served by CARE-funded programs, so it underestimates the total percent of funds serving women, infants, and children. The percentage for Title II funds, also based on the AAR, was 16.7%. Services for women for the current fiscal year were not changed significantly enough to substantially affect that figure. The percentage of CARE funds spent on women has increased over the last few years, from 15.7% in 1996 and 17.7% in 1997 to 18.5% in 1998. This is consistent with the fact that the proportion of AIDS cases which are women is increasing.

San Francisco is clearly in compliance with this requirement, and does not need to make any changes to meet this mandate. The only implication is that the Council should not cut large amounts of services for women and children.

AIDS OFFICE
25 VAN NESS AVENUE, SUITE 500
SAN FRANCISCO, CA 94102 - 6033
415 - 554-9000
FAX 415 - 431-7547

(Attach E)

PRIORITIZATION 2000-2001
OVERVIEW/CONSENSUS
August 9, 1999

Building on the past two years' prioritization processes, the following themes are outlined below to provide an overall framework for priorities in FY 2000-01.

1. ***Maximizing access to insurance and entitlements:***
   - Anticipate reduction in CARE funds
   - Maximize eligibility of clients
   - CARE funds used as last resort
   - Need commitment from the City to offset loss of funds

2. ***Housing***
   - Greatest unmet and unsatisfied need
   - Largest barrier to access and effectiveness of other services
   - Largely a problem of lack of capacity and abysmal quality

3. ***Integration of Services***
   - Housing and Primary Care as centers of integrated services
   - Services for clients where they are: home based, mobile teams drop-in, flexible and after-hours
   - Multiple services, including health care, mental health, housing and substance abuse services at single site by a multi-disciplinary team of providers giving a range of services (triage, assess,.etc)
   - Consolidation of contracts and integration of funding streams

4. ***Outreach/Education***
   - Reach marginalized & hard to reach populations, e.g. thru the use of incentives, mobile teams, HIV testing, media campaigns, peer advocacy
   - Information/Referral/Education about the system of care for both clients, potential consumers and service providers
   - Cultural and linguistic competencies

5. ***Client-centered outcomes and evaluation of services***
   - Client-centered and client-defined, in relationship to the following:
     - Access to treatment and other services
     - Utilization of services and adherence to care
     - Quality of life/positive changes for clients
     - Harm reduction goals and interventions
     - Quality of services and competence of providers

FY2000-2001 CARE PRIORITIZATION OVERVIEW/CONSENSUS

1. Access to services must be prioritized for people with the highest need (see definition of severe need population, next page)

2. HIV specific services (including CARE funded services) must be coordinated with and integrated into the larger health care and social services delivery systems (including the Department of Public Health, Community Substance Abuse Services, Community Mental Health, the Department of Human Services, the Redevelopment Agency and other housing services)

3. HAART (Highly Active Antiretroviral Treatments) and effective prophylaxis against opportunistic infections have fundamentally changed service needs for many individuals and we must continue to reexamine all service categories toward the goal of increasing access to these therapies.

4. Primary medical care for people living with HIV must be at the center of the service delivery system and all components must be connected to primary care, especially access to HIV treatment

5. In order to make a more integrated system of services available to those not currently receiving care; more effective outreach must become part of the overall system of services. This should include mobile services which reach out to individuals in need where they live, including the street.

6. Client outcomes and outcome measures must be more clearly defined in order to evaluate the effectiveness of specific services and the delivery system as a whole, and to ensure quality of care.

7. It is the responsibility of the HIV Health Services Planning Council to provide the grantee (the Department of Public Health) with clear mandates, directives and time lines, and to oversee the progress of the implementation of the Council's plan.

8. This year's prioritization will produce a two-year plan, building on the past two years' prioritization plans and the evaluation of their implementation.

(Attach. B-F)

PRIORITIZATION 2000-2001
SERVICE CATEGORY RANKING
August 9, 1999

Prior year ranking 1999-2000	*proposed ranking 2000-2001*
1. HEALTH CARE	1. HEALTH CARE
2. HOUSING	2. HOUSING
3. FOOD	3. FOOD
4. MENTAL HEALTH	4. MENTAL HEALTH
5. SUBSTANCE ABUSE	5. SUBSTANCE ABUSE
6. CASE MANAGEMENT	6.CASE MANAGEMENT
7. CLIENT ADVOCACY	7. CLIENT ADVOCACY
8. ADOPTION/FOSTER CARE	*8. TRANSPORTATION*
9. DAY/RESPITE CARE	*9. DIRECT EMERG.ASSIST*
10. PLANNING COUNCIL SUPPORT	10. ADOPTION/FOSTERCARE
11. PROGRAM SUPPORT	11. DAY/RESPITE CARE
12. TRANSPORTATION	12. PLANING COUNCIL SUP
13. DIRECT EMERGENCY ASSIST.	13. PROGRAM SUPPORT

HIV HEALTH SERVICES PLANNING COUNCIL

August 23, 1999 4:30 - 7:30 PM

Room 201 - City Hall - 1 Dr. Carlton B. Goodlett Place

22

3/99

Agenda

I.	Call to order	4:30 PM
II.	Roll Call	4:32 PM
III.	Review and Approval of Agenda	4:35 PM
IV.	Review and Approval of Minutes - 5/26/99 - VOTE	4:37 PM
V.	General Announcements	4:40 PM
VI.	Public Comment	4:55 PM
VII.	Nominations for Council Co-chairs (vote on 9/27)	5:10 PM
VIII.	Prioritization Plan 2000-2001 - VOTE	5:20 PM
	• Break - 15 minutes	
IX.	New Business	7:25 PM
X.	Adjourn	7:30 PM

Upcoming meetings:

DATE	GROUP	PLACE	TIME
Monday, August 30	Membership Committee	25 Van Ness Ave. Rm. 330-A	5:30 - 7:30 PM
Wednesday, September 1	Housing Committee	25 Van Ness Ave. Rm. 330-A	4:00 - 6:00 PM
Wednesday, September 1	PWA Caucus	25 Van Ness Ave. Rm. 330-B	5:30 - 7:00 PM
Monday, September 13	Steering Committee	25 Van Ness Ave. 5th flr. conf rm.	5:00 - 7:30 PM
Monday, September 27	Planning Council	City Hall, Rm 201	4:30 - 7:30 PM
Monday, October 25	Planning Council	City Hall, Rm 201	4:30 - 7:30 PM

DOCUMENTS DEPT.

AUG 20 1999

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PUBLIC LIBRARY

SF Dept. of Public Health — AIDS Office, 25 Van Ness, 5th floor
City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

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Minutes, August 23, 1999 HIV Health Services Planning Council

I. **Call to Order**
4:30 PM

II. **Roll Call**
Attachment A, Column 1

III. **Review and approval of Agenda**
The agenda was approved.

IV. **Review and approval of Minutes**
The 5/24/99 minutes were approved. *VC* and *AR* abstained.

V. **General Announcements**

- *DJ* announced: (1) The next council meeting, 9/27/99, will focus on council Co-chair elections, and a discussion of community forums. (2) The 10/25/99 council meeting will have a final presentation of the Grantee Assessment by Barbara Rosa. (3) The Evaluation and Implementation Committee will resume meeting on Monday, September 20, 1999, 5-7 PM, 25 Van Ness Ave. The committee will work on proposals for funding reductions, one-time funding of unobligated funds, and the timeline for the two-year workplan.
- *AM* noted that the Grantee Assessment Task Force would be meeting Thursday, September 16, 4-5 PM, 25 Van Ness. He said that the minutes from the 7/22/99 meeting of the task force were not mailed.
- *Laura Thomas* distributed to specified members: Representation Information Form, to be completed by the end of this meeting, and Statement of Economic Interest, to be completed by the end of this week.

VI. **Public Comment**

- *Bill Barnes*, AIDS Policy Advisor, Mayor's Office, said that the current list of council recommended appointments is before the mayor now. He warned that there would be less CARE Act money in the future. He suggested looking for other funding streams that might be available.
- *Michael Petrelis* reported a story published in the Orlando Sentinel on 8/21/99 regarding $240,000 missing from an AIDS charity. He asked that council members read the story at www.orlandosentinel.com.

VII. **Nominations for Council Co-chairs**
DJ said the nominations would be voted on at the 9/27/99 council meeting, and that nominations can be made up to that date. She reminded the council that the Bylaws state that three co-chairs will be elected to a one-year term. At least one must be living with HIV , one must be a woman, and one must be a person of color. One person can fill all those requirements.
TL nominated the following slate: *SJ, SS,* and *EW.*
LO'C nominated *LG* and *SO. SO* declined.
LO'C asked what meetings the council co-chairs attended in addition to the council's meetings.
DJ said that they have regular meetings with representatives of the AIDS Office, the Mayor's Office, the joint planning council meetings of the DPH including HIV Prevention, CARE, Treatment on Demand, Mental Health, and Women and Children are the participants who focus on integrating services.

VIII. **Prioritization Plan 2000-2001**

DJ said *TC* would review the Defining Severe Need document. She suggested then discussing the prioritization recommendations in reverse order. She said Sections 1-4 of the document have been approved by prioritization committees, but Section 5 has not had the benefit of committee review. Some proposed amendments were included with this document in the mailing. The order of discussion and times allotted were:

5. Client-Centered Outcomes & Evaluation - 30 minutes.
4. Outreach/Education - 15 minutes.
3. Integration of Services - 15 minutes.
2. Housing - 10 minutes.
1. Maximizing Access & Eligibility - 10 minutes.

TC said the recommendations were being made assuming there would be no additional dollars to spend on programs, so the focus was on serving individuals with the most severe need, and to change the existing system rather than adding to the system. He said there were four criteria, mandated by HRSA, to be considered when setting priorities: need, cost effectiveness, other sources of money, and the priorities of the community being served.

DEFINING SEVERE NEED [Attachment B]

- *TC* offered the document as a motion to be voted on.
  The categories were:
  Criteria which define Severe Need - this section defines what is meant by "uninsured or under insured", "poverty", and "HIV/AIDS disability, severity of illness".
  Co-morbidity factors - those which contribute to severe need - homelessness, active substance use, mental illness, tuberculosis, sexually transmitted disease, and hepatitis.
  Examples of common barriers facing underserved populations experiencing Severe Need - immigrants, women and families with children, adolescents/young persons, African Americans, transgenders.
  TC said that *VC, LG, NR, Laura Thomas*, and he worked on the document.
- *SK* proposed an amendment to add "dementia" to the list of co-morbidity factors. The amendment was seconded.
  Discussion: *DB* said that dementia falls under the category of mental illness. *VC* suggested the wording be "AIDS related dementia" specifically. *SS* spoke against the motion because there are many things related to HIV that could be included in a list.
  Vote: The amendment to the motion failed. [2]

BC asked if "HIV/AIDS disability" was defined under the Americans with Disabilities Act (ADA). *TC* said the ADA may not be the best definition of severe need. *AB* asked if the definition of transgenders included all ethnic groups. *DJ* said it did. *KW* was confused by the multiple use of the word "disability" under HIV/AIDS disability, severity of illness. It seemed to mean different things in different places. *GL* suggested changing the wording to read "For these individuals, defining eligibility based on 'severe need' . . . ".

- *NN* proposed an amendment changing the wording under Criteria which define Severe Need: HIV/AIDS disability, severity of illness: to read "defining disability in terms of HIV-related disability alone does not address 'impairments' experienced by HIV-positive individuals . . .". The proposal was seconded.
- *SS* proposed an amendment to change the wording under Criteria which define Severe Need: HIV/AIDS disability, severity of illness: "For these individuals, defining eligibility ~~based on disabilities~~ related to co-morbidity factors . . . ". The proposal was seconded.
  Vote: The two amendments to the motion were combined and passed. [3]

Vote: The motion to approve the wording of the Defining Server Need document with the approved amendments passed. [4]

Recommendations
The following five sections were offered as separate motions to be voted on. [Attachment C]

5. CLIENT-CENTERED OUTCOMES & EVALUATION
   - *AM* proposed an amendment to add "Direct the AIDS Office to assess the availability of emerging diagnostic testing, such as geno-type and pheno-type testing." [Attachment D] *JB* seconded the proposal with the stipulation that it moves to the Maximizing Access & Eligibility section. *AM* agreed.
   - *TC* proposed an amendment to sub-section B. Housing to add "Improve conditions in SROs used for emergency transitional housing, using coordinated efforts between the provider and city agencies." The proposal was seconded.
     Vote: The amendment to the motion passed. [5]
   - *TC* proposed an amendment to sub-section C. Mental Health to add "Develop strategies to address client need for social support." The proposal was seconded.

TL said that rather than read every name for every vote, if there is consensus, the presiding officer can say, " If there are no objections the motion passes by acclamation." It must be a unanimous vote and will be documented as a YES vote for each present member. If there are any objections the vote must be recorded by roll call.

Vote: The amendment to the motion passed. [6]
- *DJ* proposed an amendment to sub-section D. Substance Use that would replace the second bullet item of the motion. [Attachment E] The proposal was seconded.
  Vote: The amendment to the motion passed. [7]
- *LO'C* proposed an amendment to sub-section D. Substance Use under the first bullet item of the motion to strike the word "residential" from the first sentence which would then read "The Planning Council and AIDS Office should work with CSAS and the TOD Council to ensure appropriate **HIV/AIDS training** for all non-HIV-specific substance use programs, especially programs for women with children."
  Vote: The amendment to the motion passed. [8]
  Vote: The motion to approve the wording of Section 5. Client-Centered Outcomes & Evaluation with the approved amendments passed. [9]

4. OUTREACH/EDUCATION
   - *GL* proposed an amendment to sub-section E. Other Support Services to add a bulleted item "Publish and distribute to all providers and updated *printed* guide to HIV Services."
     Discussion: *KB* was concerned that other funding sources be used in addition to CARE dollars, and that language should be included in the amendment to reflect that. *SO* wondered if the project would actually happen. *Michelle Long Dixon* said there were funds earmarked for this project. *LDLT* said he was concerned about training people how to use the system. *TC* noted that this proposal would be in addition to training. *EW* said that all the current information is available through the public library on their web site which is updated monthly. Providers have access to that information 24 hours a day. *MS* asked *Michelle* where funds were coming from. *Michelle* said they were CARE Act funds. He also noted that many people don't have access to the internet if that's the only place it's available. *SJ* shared that concern and asked what this book would cover that's not currently being covered. *GL* said it would be updated information. The current book is three years old and much of the information is outdated. He noted that the needs

assessment indicated that access to service was a common complaint of clients that this publication could help resolve.
The proposal was seconded.
LDLT suggested that CARE funds not be used for this purpose. *JO* said that there needs to be a budget to translate the publication into Spanish in both book form and on the internet. *TC* spoke in favor of the motion as it stands without this amendment. *SJ* also spoke in favor of the motion as it stands. *JO* said any resource publication needs to reach all providers and there needs to be funding to translate it into Spanish. *Michelle* said that this discussion is being had in the AIDS Office and will continue as funds are made available. *DJ* cautioned the council not to discuss implementation.
Vote: The proposed amendment to the motion passed. [10]

- *GL* proposed an amendment to sub-section C, Mental Health, to add a bulleted item to "Provide clear and easily-utilized procedures to non-mental health providers for referring clients who are in emotional crisis to immediate mental health assessment and access to appropriate care." The proposal was seconded.
  Discussion: *MJW* suggested changing the word "immediate" to "timely". *GL* agreed. *MDS* asked what would happen when immediate and timely were the same. *DJ* said that San Francisco has immediate mental health crisis services available. *JO* suggested changing the wording ". . . to 'timely and adequate' mental health assessment and access to appropriate care." GL agreed. DB pointed out that it's the emotional crisis that determines what care is needed.
  Vote: The proposed amendment to the motion with agreed wording changes passed. [11]
- *TC* proposed an amendment to sub-section B, Housing, to add a bulleted item , "Improve Outreach to homeless people living with HIV/AIDS." The proposal was seconded.
  Discussion: *LO'C* asked if this wasn't covered under the Housing section. TC said this item was intended to be specific to Outreach. *KB* asked how this item was different than the first bullet under Outreach/Education. *TC* agreed it was implied in the item KB referred to but that it needed to be emphasized in Housing. *JB* did not think the language was excessive given the lack of housing in the EMA.
  Vote: The proposed amendment to the motion passed. [12]

MJW noted that in sub-section D, Substance Use, under the first bullet, the word "residential" should be removed as it was in Section 5.

- *BC* proposed an amendment to sub-section C, Mental Health, to add a bulleted item "Improve outreach for mental health services through peer advocacy and treatment advocacy staff.." The proposal was seconded.
  Discussion: *MJW* said that in the Mental Health workgroups there was no need expressed for increased outreach. *DB* spoke in favor of the proposal and said that it was a capacity issue among providers. *DJ* spoke against the proposal until there can be exploration of whether the mental health services being provided to clients are appropriate. *MS* spoke in favor of the proposal, he felt there was a need for mental health outreach. *JB* spoke in favor of the proposal.
  Vote: The proposed amendment to the motion failed. [13]
  Vote: The motion to approve the wording of Section 4. Outreach/Education with the approved amendments passed. [14]

3. INTEGRATION OF SERVICES
   GL proposed an amendment to sub-section A, Health Care, to replace the fifth and sixth bulleted items with the following: [Attachment F]

- "Provide a full range of complementary therapies, including acupuncture, therapeutic exercise, therapeutic massage, nutritional counseling, herbal therapy, and nutritional supplementation."
- "Support the integration of complementary therapies into CARE-funded primary care sites."
- "Provide acupuncture at all primary care sites."
- "Support the incorporation of acupuncture into substance use services." The proposal was seconded.

Discussion: *NN* spoke against both the motion and the amendment saying there needs to be more information about how these services would be implemented and what the costs would be. *LO'C* thought that acupuncture does not need to be at all primary care sites.
Vote: The proposed amendment to the motion failed. [15]

- *MJW* proposed an amendment to sub-section A, Health Care, to "strike the fifth bulleted item." The proposal was seconded.
  Discussion: *KB* said the Health Care workgroup determined that complementary therapies should be available, but not necessarily paid for by CARE funds. *SO* asked MJW to explain why she was opposed to the item. *MJW* said it was partly due to decreased funding, that CARE funds currently pay for most complimentary therapies. With limited resources offering a full range of complimentary therapies is inappropriate.
  DB proposed an amendment to the amendment to reword the fifth bulleted item to read "Request that the **full range of complementary therapies** be made available to people living with HIV/AIDS." The amendment to the amendment was seconded.
  Discussion: *SJ* pointed out that the question had been called on this motion before the amendments were proposed. *DJ* noted that the discussion was going beyond the consensus on the motion.
  Vote: The proposed amendment to the amendment to the motion failed. [16]
  Vote: The proposed amendment to the motion failed. [17]
  Vote: The proposed motion passed. [18]
  JB proposed a motion to vote on Sections 1 and 2 as they stand, including *AM*'s proposed amendment for Section 1, sub-section A, Health Care, concerning geno-type and pheno-type testing. [Attachment [D] The proposal was seconded.
  Vote: The proposed motion passed. [19]

2. HOUSING
   Vote: The proposed motion passed. [20]

1. MAXIMIZING ACCESS & ELIGIBILITY
   Vote: The amended motion passed. [21]

IX. **New Business**
LDLT told new members they need to continue to pressure for timely appointments to the council so that in the future there will not be so many members being appointed when it's too late to fully participate in prioritization.

IX. **Adjournment**
7:45 PM

HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

8/23/99		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
1. Alliena Baker	*AB*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Kirsten Balano	*KB*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3. Hazel Betsey	*HB*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4. Donald Bliss	*DCB*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	B
5. Jeff Byers	*JB*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6. Tom Calvanese	*TC*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
7. Bart Casimir	*BC*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8. Veronika Cauley	*VC*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9. Julie Charubusapayon	*JAC*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10. Raymond Combs	*RC*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
11. John Conley	*JC*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
12. Luis De La Torre	*LDT*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13. Mark Dunlop	*MD*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
14. Gregory Edwards	*GE*	A											
15. Gene Gowdey	*GG*	A											
16. Laura C. Guzman	*LCG*	A											
17. Siddiq Jihad	*SJ*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18. Diane Jones	*DJ*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
19. Sam Kaplan	*SK*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
20. Tony Leone	*TL*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
21. Gene London	*GL*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
22. Allen Meyer	*AM*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
23. Jim Mitulski	*JM*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
24. Lee Ann Monfredini	*LM*	A											
25. Norm Nickens	*NN*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
26. Lisa O'Connor	*LO'C*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
27. Loras Ojeda	*LO*	A											
28. Jorge Ortiz	*JO*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
29. Stephan Oxendine	*SO*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
30. Ken Pearce	*KP*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
31. Alissa Riker	*AR*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
32. Nilda Rodriguez	*NR*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
33. Matthew Sharp	*MS*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
34. Susan Shea	*SS*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
35. Mike Shriver	*MDS*	P			Y	Y	Y	Y	Y	Y	Y	Y	Y
36. Al Terrazas	*AT*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
37. Kelly Wallace	*KW*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
38. Eric Whitney	*EW*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
39. Mary Jane Wood	*MJW*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

8/23/99		[13]	[14]	[15]	[16]	[17]	[18]	[19]	[20]	[21]	[22]	[23]	[24]
1. Alliena Baker	*AB*	N	Y	N	B	N	Y	Y	Y	Y			
2. Kirsten Balano	*KB*	N	Y	N	N	N	Y	Y	Y	Y			
3. Hazel Betsey	*HB*	N	Y	N	N	N	Y	Y	Y	Y			
4. Donald Bliss	*DCB*	Y	B	Y	Y	N	Y	Y	Y	Y			
5. Jeff Byers	*JB*	N	Y	N	N	N	Y	Y	Y	Y			
6. Tom Calvanese	*TC*	N	Y	B	N	N	Y	Y	Y	Y			
7. Bart Casimir	*BC*	Y	N	Y	N	N	Y	Y	Y	Y			
8. Veronika Cauley	*VC*	N	Y	N	N	N	Y	Y	Y	Y			
9. Julie Charubusapayon	*JAC*	N	Y	B	N	N	Y	Y	Y	Y			
10. Raymond Combs	*RC*	Y	Y	B	Y	N	Y	Y	Y	Y			
11. John Conley	*JC*	N	Y	N	N	Y	Y	Y	Y	Y			
12. Luis De La Torre	*LDT*	B	Y	B	N	N	Y	Y	Y	Y			
13. Mark Dunlop	*MD*	N	Y	N	N	N	Y	Y	Y	Y			
14. Gregory Edwards	*GE*												
15. Gene Gowdey	*GG*												
16. Laura C. Guzman	*LCG*												
17. Siddiq Jihad	*SJ*	N	Y	B	N	Y	Y	Y	Y	Y			
18. Diane Jones	*DJ*	N	Y	B	N	N	Y	Y	Y	Y			
19. Sam Kaplan	*SK*	N	Y	N	N	Y	B	Y	Y	Y			
20. Tony Leone	*TL*	N	Y	N	N	N	Y	Y	Y	Y			
21. Gene London	*GL*	N	Y	Y	B	N	Y	Y	Y	Y			
22. Allen Meyer	*AM*	N	Y	N	N	N	Y	Y	Y	Y			
23. Jim Mitulski	*JM*	N	Y	N	N	N	Y	Y	Y	Y			
24. Lee Ann Monfredini	*LM*												
25. Norm Nickens	*NN*	N	Y	N	N	Y	Y	Y	Y	Y			
26. Lisa O'Connor	*LOC*	Y	Y	B	N	N	Y	Y	Y	Y			
27. Loras Ojeda	*LO*												
28. Jorge Ortiz	*JO*	Y	Y	Y	Y	Y	B	Y	Y	Y			
29. Stephan Oxendine	*SO*	N	Y	N	N	N	Y	Y	Y	Y			
30. Ken Pearce	*KP*	Y	Y	N	Y	B	B	Y	Y	Y			
31. Alissa Riker	*AR*	N	Y	Y	N	N	Y	Y	Y	Y			
32. Nilda Rodriguez	*NR*	N	Y	B	N	N	Y	Y	Y	Y			
33. Matthew Sharp	*MS*	Y	Y	N	N	N	Y	Y	Y	Y			
34. Susan Shea	*SS*	N	Y	B	N	N	Y	Y	Y	Y			
35. Mike Shriver	*MDS*	N	Y	N	N	N	Y	Y	Y	Y			
36. Al Terrazas	*AT*	N	Y	N	N	N	Y	Y	Y	Y			
37. Kelly Wallace	*KW*	N	Y	N	Y	Y	Y	Y	Y	Y			
38. Eric Whitney	*EW*	N	Y	N	N	N	Y	Y	Y	Y			
39. Mary Jane Wood	*MJW*	N	Y	Y	N	Y	N	Y	Y	Y			

ATTACHMENT B

2000-2001 CARE PRIORITIZATION
DEFINING SEVERE NEED

CRITERIA WHICH DEFINE SEVERE NEED:

Uninsured or under insured: not insured for the service being provided by CARE (CARE must be used as funding source of last resort). This may vary depending upon type of service. For example, someone may have private insurance which does not cover dental, or may have Medi-Cal, which does not cover certain needed services.

Poverty: the Council has defined income eligibility for housing assistance as 25% of median income: $12,000 for 1 person, $17,500 for a family of 4 (1998-1999 figures).

HIV /AIDS disability, severity of illness: defining disability in terms of HIV-related disability alone does not address disabilities experienced by HIV-positive individuals who may be disabled in other ways, by mental health diagnoses, for example. For these individuals, defining eligibility based on disabilities related to co-morbidity factors may be desirable and allow services to be targeted to those experiencing more severe need than is currently the case. In addition, it may be necessary to continue to prioritize certain services for those in more advanced stages of HIV disease, in which case, more specific criteria would need to be determined.

COMORBIDITY FACTORS - THOSE WHICH CONTRIBUTE TO SEVERE NEED:

homelessness
active substance use
mental illness
tuberculosis
sexually transmitted disease
hepatitis

EXAMPLES OF COMMON BARRIERS FACING UNDERSERVED POPULATIONS EXPERIENCING SEVERE NEED:

This is not intended to be an exhaustive list. A comprehensive needs assessment has been conducted, and given some limitations to the data collection methods and findings, certain barriers to service and levels of unmet need for certain populations have been clearly identified.

IMMIGRANTS: linguistic and cultural barriers, immigration status, and ineligibility for other forms of public assistance, particularly for Latinos/as.

WOMEN AND FAMILIES WITH CHILDREN: unmet need for childcare, transportation, unique disease profile in both women and children.

ADOLESCENTS/YOUNG PERSONS: lack of knowledge of available services, high incidence of homelessness, need for education of adult service providers, lack of continuum of services across age groups, gaps in services experienced by individuals made more vulnerable by periods of transition.

AFRICAN AMERICANS: disproportionate rate of HIV infection, particularly among male to female transgenders, as well as disproportionately low levels of access, particularly to HIV antiviral and prophylaxis treatments.

TRANSGENDERS: disproportionate rate of HIV infection, particularly among African American male to female transgenders; lack of understanding, insensitivity and discriminatory treatment, particularly in accessing health care, housing and residential substance abuse treatment.

8/17/1999

1. MAXIMIZING ACCESS & ELIGIBILITY

Maximizing access to insurance and entitlements:

- Anticipate reduction in CARE funds
- Maximize eligibility of clients to public, cash and health insurance benefits
- CARE funds used as last resort
- Need commitment from the City to offset loss of funds

A. Health Care

- Target funds to support the **quality of care** and effective **utilization** of services
- **Reallocate home infusion funds to attendant care** and identify other, more cost-effective service options for infusion clients
- Maximize use of **other funding streams for dental care**, especially Medi-Cal and dental reimbursement.
- Maximize use of **Medi-Cal for home health care** (including use of the Medi-Cal waiver program)
- **Analyze the utilization of and need for attendant care** as compared to the need for practical support services
- **Pharmaceutical staffing** services need to be augmented with General Fund dollars in order to improve the quality of service for CARE clients

B. Housing

- Integrate **benefits counseling and money management** with housing to maximize effectiveness of housing resources in combination with entitlements.
- **Transfer** HOPWA-eligible CARE **subsidy recipients to all available HOPWA subsidies**, in order to fully utilize HOPWA funds budgeted for subsidies. Re-direct CARE subsidy funds made available through this to individuals and housing units ineligible for HOPWA.
- Analyze the **calculation of the number of HOPWA units in mixed housing developments** based on up front HOPWA capital contribution and change to more accurately reflect tenant rent contribution and ensure that the maximum number of HOPWA units are included in new developments.

C. Mental Health

- Increase the emphasis on **mental health assessments** funded through outpatient mental health services for those clients not necessarily ready for on-going treatment, but who require assessments for completion of benefits enrollment.
- Direct the AIDS Office (AO) to work with contractors to assure that **existing contractors** provide mental health assessments to existing clients as required by SSI, SSDI, etc.
- Direct the AO to assure that each agency assess for **client eligibility** including insurance and income.
- Direct the AO to explore the implications of prioritizing the funding of **group therapy** more than individual therapy, in relationship to cost-effectiveness and client needs. This is not a

recommendation to change the existing balance, but rather a request that there be an exploration of the ramifications, positive and negative, if such a shift were made.

D. *Substance Use*

- [insert additional recommendation here]

E. *Other Support Services*

- Maximize insurance/benefits **eligibility and enrollment** for clients
- Investigate possibility of contracting with one **cab company** for guaranteed transportation services.
- Change **eligibility criteria** for direct emergency financial assistance to focus on clients with the most severe needs, HIV, and a disability or co-morbidity. [see Severe Need definition]
- Maximize buying power for food by utilizing **food bank** to purchase food for direct distribution to clients at multiple agencies.

2. HOUSING

Housing

- Greatest unmet and unsatisfied need
- Largest barrier to access and effectiveness of other services
- Largely a problem of lack of capacity and abysmal quality

A. Health Care

B. Housing

- Improve **integration of all housing assistance funds**, including direct emergency financial assistance, and other emergency housing assistance funds, with the goal of coordinating available resources to maximize effectiveness in establishing residency and stability.
- Expand **decentralized access to emergency housing vouchers** and shallow rent subsidies through expanded integrated services network, including DPH clinics, case management and peer advocacy programs, and at drop-in centers, and agencies serving persons in housing crisis (such as ALRP), also including after hours availability.
- Use emergency vouchers to **block out a number of rooms** in one hotel.
- Implement **centralized complaint and tracking system**
- **Educate emergency hotel staff** about housing programs and available support services, such as crisis intervention and practical support.
- Initiate **team inspections** with staff from DBI, DPH, DHS, SFFD, and Emergency Housing Program Staff, with the goal of increasing code compliance and enforcement.
- Develop more **flexible eligibility criteria** for homeless emergency housing recipients to reduce incidence of denial of emergency housing for homeless due to documentation issues or limited hours of availability.
- Make CARE subsidies available **outside San Francisco** but within the EMA.
- Direct DPH Housing Unit to identify additional funding for **shallow rent subsidies.**
- Redirect resources to **master leasing** of buildings, sublet with on site integrated support services, including primary care. Project-base portion of subsidies.
- Support **harm reduction** model housing for active users.

C. Mental Health

D. Substance Use

- Shift a portion of funding from residential programs to **housing with an appropriate level of supportive services,** based on client needs.

E. Other Support Services

3. INTEGRATION OF SERVICES

Integration of Services

- Housing and primary care as centers of integrated services
- Services for clients where they are: home based, mobile teams drop-in, flexible and after-hours
- Multiple services, including health care, mental health, housing and substance abuse services by a multi-disciplinary team of providers giving a range of services (triage, assess,.etc)

A. Health Care

- Increase access to **attendant care** in clients' homes and residences (including SROs)
- Better **integrate home health and medical care with substance use** providers, especially residential substance use facilities, to enable clients to stay in residential facilities.
- Improve integration of decentralized **dental services with ISPs**
- Further **decentralize dental services**: expand available services and co-locate at additional sites.
- Request that the **full range of complementary therapies** be provided at all CARE-funded primary care sites. In particular, acupuncture should be provided at all primary care sites.
- Better **integrate complementary therapy** with other services, especially substance use.
- Using all available methods, continue to target all **CARE-funded contracts** to provide integrated services. Those integrations can be within organizations, among organizations, or both.

B. Housing

- Integrate housing assistance funds including both emergency and subsidy funds with other services, and other sources of housing assistance to provide **on site integrated services in congregate supported housing**. Identify vacant buildings which could house integrated service models, including co-locating primary care and supported housing, to help stabilize unstable clients.
- Expand **decentralized access** - expand link to emergency housing
- Integrate **benefits counseling and money management** with housing to maximize effectiveness of housing resources in combination with entitlements.
- Ensure that **practical support** is provided within housing programs, esp. SROs used for emergency housing.
- Increase **legal advocacy for eviction prevention**. Make emergency housing and direct emergency financial assistance funds, including eviction prevention funds, available at legal advocacy sites.

C. Mental Health

- Direct the AO to explore the implications of requiring that 20% of the mental health money be included in **collaborations with non-mental health agencies.**
- Direct the AO to explore the implications of requiring that 10% of the mental health money be included in **collaborations with youth-focused (25 y/o or under) agencies.**

4. OUTREACH/EDUCATION

Outreach/Education

- Reach marginalized & hard to reach populations, e.g. through the use of incentives, mobile teams, HIV testing, media campaigns, or peer advocacy in coordination with other health outreach efforts
- Implement information/referral/education system for clients, potential consumers, and service providers.

A. Health Care

- *[Pending Severe Need definition: Address lack of cultural sensitivity to women, including those with children, transgenders, and heterosexuals]*

B. Housing

- Create **outreach and advocacy training program** for clients searching for housing, and for peer advocates helping clients find housing.

C. Mental Health

D. Substance Use

- Improved **outreach to the jail population** is needed. This includes better linkages to all services on release from jail, e.g. intakes in jail prior to release, and picking up clients at jail and transporting them to programs. Pre-release planning and counseling services need to be offered to all incarcerated clients seeking substance abuse services.
- *[Pending Severe Need definition: All agencies must accept and appropriately serve the transgendered population. Transgender should be considered a cultural competency category (in terms of staff hiring and training).]*
- The Planning Council and AIDS Office should work with CSAS and the TOD Council to ensure appropriate **HIV/AIDS training** for all non-HIV-specific residential substance use programs, especially programs for women with children. The training should focus on providing services to people with HIV/AIDS, including medication interactions, side effects, adherence, and pain management.
- **Spanish** language capacity in residential programs should be increased.
- Provide **training** on: transgender issues; HIV/AIDS for CSAS programs (e.g. TECP-like program for staff in residential facility)

E. Other Support Services

- Increase **outreach** to women with children about the availability of child care
- Train providers on benefits and entitlements.

D. Substance Use

- Improved **outreach to the jail population** is needed. This includes better linkages to all services on release from jail, e.g. intakes in jail prior to release, and picking up clients at jail and transporting them to programs.
- Keep track of **regulatory changes to methadone** programs. I.e., if physician-prescribed methadone becomes available, re-evaluate services in this category.
- Improve collaborations and linkages of outpatient services with **integrated services**, e.g. increase number of counselors stationed at ISP's.
- Improve collaboration with primary care providers to provide **medical support to residential facilities** so that clients who are ill may remain in the facilities.

E. Other Support Services

- Analyze services used by families with children, and organize into a **family-centered** system of care. Particularly child care, family legal services, etc. Integrate existing services to address gaps in the continuum of care for families with children.
- Better **coordination of case managers** for each client (for clients with more than one case manager) through:
    - Defining and applying the definition of "case manager"
    - Surveying current programs to determine the number and function of case managers funded outside of the Case Management category.
    - Conducting an assessment to determine: how many case managers an individual client has; whether the use of multiple case managers is appropriate (contractually driven, need based, or programmatically mandated); which programs mandate case management in order for clients to receive other services; and how case managers are trained and what are the qualifications needed to provide case management.
    - Investigating the feasibility of clients designating a primary case manager through surveying clients, case managers, and program administrators.
- Treatment advocates, peer advocates, and case managers must be better integrated with the **primary care** providers and medical care team.
- **Move** current contract in "Adoption/Foster care" to this category. **Evaluate** overall need for legal services and **expand definition of legal services** to include family law , housing, etc. Consolidate legal services in one service category, and ensure that they are responsive to the current needs for legal services.
- If appropriate, **move funding** from "Adoption/Foster Care" to "Legal/Immigration Services" category, and **restructure** to allow for family law services and other needed legal assistance.
- Better integrate/link money management with **housing services**

Not yet discussed, 8/16/99

5. CLIENT-CENTERED OUTCOMES AND EVALUATION

Client-centered outcomes and evaluation of services.
Client-centered and client-defined, in relationship to the following:

- Access to treatment and other services
- Utilization of services and adherence to care
- Quality of life/positive changes for clients
- Harm reduction goals and interventions
- Quality of services and competence of providers

A. Health Care

- Increase access to **attendant care** in clients' homes
- Train current **dental providers** on HIV care to expand pool of available providers

B. Housing

C. Mental Health

Passed — Unanimous

D. Substance Use

- The Planning Council and AIDS Office should work with CSAS and the TOD Council to ensure appropriate **HIV/AIDS training** for all non-HIV-specific residential substance use programs, especially programs for women with children. The training should focus on providing services to people with HIV/AIDS, including medication interactions, side effects, adherence, and pain management.
- Continue shift in outpatient services towards **harm reduction** and drug use management.

E. Other Support Services

- **Training** for peer advocates on standards of practice and other service-related issues (e.g. boundaries, preventing burnout, etc.)
- Ensure that a minimum of 25% of peer advocacy time in each program is spent providing **practical support** to clients.
- Consider more **flexible van schedule** to accommodate services and events on evenings and weekends.
- Develop **standards of practice** for treatment and peer advocates within the next year.
- Provide money management with more **flexible or expanded hours**.
- Develop protocols for money management programs working with **children with guardians**.
- Greater **flexibility** in hiring child care providers, i.e. using IHSS model of hiring providers.
- Use additional funds ($180,000) in "Program Support" for "**continuing education**" and skills development for agency staff (especially peer advocates and treatment advocates).
- Develop **drop-in program** to provide social support among clients. Details to be developed by drop-in center work group.
- Define **coordination of case management**
- Clarify service definition, availability, utilization, and need for **home health care, peer advocacy, and practical support services**.

ATTACHMENT D

To: HSPC Council
From: Michael Moors <memoors@stanford.edu>
Subject: Fwd: CARE COUNCIL PRIORITIZATION
Cc:
Bcc:
X-Attachments:

>Date: Tue, 17 Aug 1999 12:41:24 -0700
>From: Allen Meyer <ameyer@sfccc.org>
>Organization: sfccc
>X-Mailer: Mozilla 2.02 (Win16; I)
>MIME-Version: 1.0
>To: romaguy@aol.com
>CC: kbalano@itsa.ucsf.edu, sshea@php.ucsf.edu
>Subject: CARE COUNCIL PRIORITIZATION
>Content-Type: text/plain; charset=us-ascii
>Content-Transfer-Encoding: 7bit
>
>Dear Diane:
>
>Thanks for your leadership with this year's prioritization. We appear to
>be making good progress, and the finish line is in sight!
>
>I have one suggested addition to the Prioritization for Client-Centered
>Outcomes and Evaluation:
>
>"Direct the AIDS Office to assess the availability of emerging diagnostic
>testing, such as geno-type and pheno-type testing."
>
>As you're probably aware, geno-type testing (especially) and pheno-type
>testing are increasingly being used to measure viral resistance and for
>salvage therapy purposes. The HRSA HIV/AIDS Bureau will soon be issuing
>draft diagnostic testing guidelines, which will include a provision on
>whether or not CARE funds can be used for geno- and pheno-type testing.
>Much like viral load testing, these tests may soon become part of the
>standard of HIV care. Because these tests are expensive (~$400/test for
>geno-type testing and ~$800/test for pheno-type testing), I would like to
>put the AIDS Office on notice that access to these tests may become an
>issue. Creative strategies may need to be developed, if CARE funds are
>inadequate or not available. For example, a couple of years ago, when
>viral load testing was beginning, SFDPH and SFCCC were able to negotiate
>an "expanded access" program with Chiron Diagnostics and SFGH lab, to
>provide low-cost viral loads, until funding was made available from the
>State EIP program. Hopefully SFAO can similarly take leadership with
>geno- and pheno-type testing, and with any other emerging diagnostics.
>
>I ran this proposal by Susan and Kirsten, the Health Care
>Prioritization Co-Chairs, after last night's meeting, and they have no
>objection to this addition.
>
>Thanks again for coordinating all this, and please let me know if you
>need additional information or if I can be of assistance.
>
>Allen Meyer
>

ATTACHMENT E

Proposal for addition to the Prioritization Plan

Submitted by Lisa O'Connor, Siddiq Jihad and Diane Jones

To be included under section 1 Maximizing Access and Eligibility/D. Substance Use as well as under section 5 Client-Centered Outcomes and evaluation/D. Substance Use, replacing the second bullet

SUBSTANCE USE/ABUSE

1. Target funds to support triage and assessments of clients who use/abuse substances; develop a range of outpatient substance use/abuse services that meet the needs of clients as determined by them in their continuum of use to encourage appropriate and cost-effective utilization of services

2. Provide a range of services along the continuum of substance use (active use, occasional use and abstinence); services should include, in addition to existing abstinence and relapse-prevention services, drug use education and management and prevention of complications of drug use (soft tissue infections, drug interactions, overdoses, etc)

ATTACHMENT E

August 23, 1999

TO: Members of the CARE Council
FROM: Gene London
RE: Prioritization

As a new Council member, I acknowledge the awesome amount and quality of work that the Council does!

I offer some suggestions for the prioritization document.

Section 4 (Outreach/Education) now directs:

- "Implement information/referral/education system for clients, potential consumers, and service providers."

In addition, I recommend adding to sub-section E (Other Support Services):

- "Publish and distribute to all providers an updated *printed* guide to HIV Services."

Based on concerns I expressed at the prioritization meeting on August 16, I propose that the following statement to be inserted in Section 4, Sub-section C (Mental Health):

- "Provide clear and easily-utilized procedures to non-mental health providers for referring clients who are in emotional crisis to immediate mental health assessment and access to appropriate care."

The Client Needs Assessment Executive Summary (p. 8) addresses the issue of "...allocating additional funding for acupuncture and herbal regimens; funding complementary therapies *in addition to* Chinese medicine; and integrating allopathic and complementary care..." [emphasis mine]

It is worth noting that, according to the Client Needs Assessment presentation to the Council on June 28, that "*most current physical problems are related to side effects of treatments.*"

And (from the Executive Summary p.3): "In almost every group, ...[lowering stress, dealing with depression] [were] frequently discussed as *essential* to maintaining and improving *physical* health." [emphasis mine]

In both HIV infection and HCV co-infection, *nutritional counseling and nutritional supplementation, as well as such disciplines as qi gong and yoga,* are proving to be of great benefit to survival and quality of life, both as direct therapy and in managing negative consequences of drug therapy.

Patients usually have access to pharmaceuticals through ADAP or other insurance, but often are unable to pay for vitamins, herbs, and other beneficial supplements (which generally cost far less than the drugs). I believe the issue of funding nutritional supplements must be addressed. I would ask the Council to support funding for CARE clients to receive nutritional and herbal supplements prescribed by properly trained providers.

In Section 3 (Integration of Services), sub-section A (Health Care), I suggest replacing the current 5th and 6th bullets with the following:

- "Provide a full range of complementary therapies, including acupuncture, therapeutic exercise, therapeutic massage, nutritional counseling, herbal therapy, and nutritional supplementation."
- "Support the integration of complementary therapies, into CARE-funded primary care sites."
- "Provide acupuncture at all primary care sites."
- "Support the incorporation of acupuncture into substance use services."

Thank you for your consideration.

HIV HEALTH SERVICES PLANNING COUNCIL

September 27, 1999 4:30 - 7:30 PM

Room 201 - City Hall - 1 Dr. Carlton B. Goodlett Place

Agenda

I.	Call to order	4:30 PM
II.	Roll Call	4:32 PM
III.	Review and Approval of Agenda	4:35 PM
IV.	Review and Approval of Minutes - 7/12, 7/26, 8/9, & 8/23 - VOTE	4:37 PM
V.	General Announcements	4:45 PM
VI.	Public Comment	4:55 PM
VII.	Reports	
	• Mayor's Liaison - Bill Barnes	5:00 PM
	• Steering Committee	5:10 PM
	Planning Council Support	5:20 PM
	• Co-chair elections	5:30 PM
	Break	5:45 PM
	• AIDS Office	6:00 PM
	• Implementation & Evaluation Prioritization follow-up proposal - VOTE	6:15 PM
	• Membership New members and additional term appointments - VOTE	6:45 PM
	• PWA Caucus Consumer Rights Advocate introduction Community forum: Bayview, October 22,1999 Stipends for HIV+ council members	6:55 PM
	• Housing - HOPWA Loan Committee representative selection	7:15 PM
VIII.	New Business	7:25 PM
IX.	Adjournment	7:30 PM

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Upcoming meetings:

DATE	GROUP	PLACE	TIME
Monday, October 4	Membership Committee	25 Van Ness Ave	5:30 - 7:00 PM
Tuesday, October 5	Eval. & Implementation	25 Van Ness Ave	5:00 - 7:00 PM
Wednesday, October 6	Housing Committee	25 Van Ness Ave	4:00 - 6:00 PM
Wednesday, October 6	PWA Caucus	25 Van Ness Ave	5:30 - 7:00 PM
Tuesday, October 12	Grantee Assessment	25 Van Ness Ave	3:00 - 5:00 PM
Tuesday, October 12	Steering Committee	25 Van Ness Ave	5:00 - 7:00 PM
Monday, October 25	Planning Council	City Hall, Rm. 201	4:30 - 7:30 PM

SF Dept. of Public Health — AIDS Office, 25 Van Ness, 5th floor
ity Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

he sites are fully accessible, assistive hearing devices and signing are provided upon adequate notice. Minutes of meetings and all information distributed to Council Members, are available for inspection and copying. For further information, call the Council's staff, 415-863-5462. The closest accessible BART Station is Civic Center. Accessible MUNI lines serving these locations are: #42 Downtown Loop, #71 Haight/Noriega, #9 San Bruno, F Line to Market & Van Ness, Metro Van Ness station. For more information about MUNI accessible services, call 923-6142. *Minutes of Meetings are tentative until formally approved by the Council.*

Minutes, September 27, 1999 HIV Health Services Planning Council

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I. **Call to Order**
4:30 PM

II. **Roll Call**
Attachment A, Column 1

III. **Review and approval of Agenda**
Agenda accepted.

IV. **Review and Approval of Minutes (VOTE)**
7/12—Approved; Abstentions: *DB*, *SK*
7/26—Approved; Abstentions: *DB*, *LO*, *JB*
8/9—Approved; Abstentions: *DB*, *LO*
8/23—Carried over

V. **General Announcements**
JC introduced *Luther Brock, Sr.*, Community Advisory Board, San Mateo County AIDS Program. *TL* introduced *Richard Bargetto*, the new Consumer Rights Advocate. *SJ* introduced *N. Harrison*, Black Coalition on AIDS. *TC* introduced *Catherine Geanuracos*, the new Title IV representative.

VI. **Public Comment**
Will Carter, former co-chair, addressed the council with his support.
Benjamin H. Staton, Derek Silva resident, read a letter (Attachment B) about poor quality of care by Catholic Charities. *DJ* referred the matter to *Richard Bargetto*, who would be accepting complaints after October 1.

VII. **Mayor's Liaison Report**
Bill Barnes was not present.

VIII. **Co-chair Elections (VOTE)**
TC nominated *LO*, who declined; *LO'C* asked if *AR* or *AM* were interested. They declined. *SS*, SJ, & *EW* elected. (Ballot tally, Attachment A, Columns 2-4.)

IX. **AIDS Office Report**
Michelle Long Dixon reported that all but $130,000 of the Rollover Request was granted. What was denied was for housing residencies and security deposits.
Laura Thomas reported on the status of the Title I Grant, which was to be mailed imminently. She thanked the council for their support. She also reported on federal appropriations for the upcoming fiscal year on Title I, and the possibility of new EMA's being added. San Francisco would lose 1% on the formula funding, but there would be additional money available through Title III. Both the federal and state SPINS Grants were successful. She had not heard yet about the status of the Technical Assistance Grant.
MJW asked about the contracts for the Black Caucus money. *Michelle Long Dixon* replied that it was in contract, start-up phase. *Billy Pick* was the program manager. Continuum was the contractor. *NN* commended *Laura* for the grant application. *DJ* asked *Michelle* if her upcoming report next month would address the unobligated funds. *Michelle* said it would. *LO* asked how much time they had to decide what to do with the $130,000. *Michelle* replied there

was an indefinite period of time, that HRSA would keep the money on the books until they decided how to spend it. She also stated that she would talk about the process of appealing the decision or leaving the money alone. *JC* encouraged members to come to San Mateo County to serve on review panels.

X. **Planning Council Support Report**

TC presented an update on revisions to the budget for Planning Council support. There were four areas of support:

1. Administrative—increased level of staff support
2. PWA Caucus—support for HIV-positive members of the council to receive a $50. a month stipend.
3. Childcare
4. Trip to Washington, D.C. for co-chairs.

Other budgeted items: $48,000—Grantee Assessment; $150,000—Needs Assessment; $58,000—Consumer Rights Advocate; $129,000—Unspent

XI. **Implementation & Evaluation Report**

SO recapped the process of prioritization. He reported on the findings of the five sub-committees, and the decision to standardize those reports. The October 5 meeting would take up the next step. He said there would be a series of interim meetings every two weeks. The goal was to meet with the AIDS Office by mid-November. There was an ad hoc Evaluation Committee composed of *Susan Shea* and *Laura Guzman*. He asked for additional volunteers to look at last year's process to see what had been done. He announced that *SS* agreed to take over Integration of Services, and that they needed someone to take over Housing.

XII. **Membership Report**

TC presided over vote on new Title IV representative, *Catherine Geanuracos*. (**VOTE**: unanimous support). He said that a motion was necessary to appoint individuals who were currently serving and wished to serve another term of two years. (*BC*, *SJ*, *JO*, *AR*, *SS*, *EW*) (**VOTE**: unanimous support to forward their names to the mayor's office for re-appointment.) He reminded people there was a new member orientation on Monday, October 18, 5:30 PM, location to be announced. *DJ* told people that *Kirsten Balano* had resigned from the council. *TC* said that the committee was being chaired by a single person, and pitched for volunteers.

XIII. **PWA Caucus**

TL announced that the Consumer Advocacy office was at 1540 Market Street, Suite 301. Telephone: 415. 863.8131. He reported that the City Attorney would be handling the return of the office equipment from the previous advocate. *LO'C* talked about the Community Forums. The first one was set for October 22. She was working on an outline that would be presented at the next PWA meeting. She brought up the possibilities of member reimbursement and of pharmaceutical company support. They talked about budgeting $300. per forum. *VC* invited everyone to attend the next caucus on October 6. *DB* stated his opposition to outside money being used and questioned reimbursement for participation. *LO'C* clarified that childcare/transportation vouchers might encourage people to come. She said it was from the Community Forum budget. *DB* asked that the statement about reimbursement be clarified. *LO'C* said it would be discussed at the upcoming meeting.

XIV. **Housing Committee Report**
AR said they were not ready for the HOPWA committee selections, and that they had to find a replacement for *TC*. She said they needed to talk about the demise of the eviction prevention program, the situation at Derek Silva that they heard about that evening, and the upcoming proposal to the Implementation Committee. She encouraged people to attend the meeting. *TC* made a pitch for participation. He presented the HOPWA Policy Recommendations (Attachment C.)

XV. **New Business**
None.

XVI. **Adjournment**
7:30 PM

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HIV Services Planning Council

Roll Call [1]: **P**=Present; **A**=Absent; **E**=Excused; **L**=Leave of Absence
Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

9/27/99			[1]	[2] SS	[3] SJ	[4] EW	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
1.	Alliena Baker	*AB*	P	X	X	X								
2.	Hazel Betsey	*HB*	P	X		X								
3.	Donald Bliss	*DCB*	P											
4.	Jeff Byers	*JB*	P	X	X	X								
5.	Tom Calvanese	*TC*	P	X	X	X								
6.	Bart Casimir	*BC*	P	X	X	X								
7.	Veronika Cauley	*VC*	P	X	X	X								
8.	Julie Charubusapayon	*JAC*	A											
9.	Raymond Combs	*RC*	P	X	X	X								
10	John Conley	*JC*	P	X	X	X								
11	Luis De La Torre	*LDT*	A											
12	Mark Dunlop	*MD*	P	X	X	X								
13	Gregory Edwards	*GE*	P	X	X	X								
14	Gene Gowdey	*GG*	P	X	X	X								
15	Laura C. Guzman	*LCG*	A											
16	Siddiq Jihad	*SJ*	P	X	X	X								
17	Diane Jones	*DJ*	P	X	X	X								
18	Sam Kaplan	*SK*	P	X	X	X								
19	Tony Leone	*TL*	P	X	X	X								
20	Gene London	*GL*	P	X	X	X								
21	Allen Meyer	*AM*	P	X	X	X								
22	Jim Mitulski	*JM*	A											
23	Lee Ann Monfredini	*LM*	A											
24	Norm Nickens	*NN*	P	X	X	X								
25	Lisa O'Connor	*LO'C*	P	X	X	X								
26	Loras Ojeda	*LO*	P	X	X	X								
27	Jorge Ortiz	*JO*	A											
28	Stephan Oxendine	*SO*	P	X	X	X								
29	Ken Pearce	*KP*	A											
30	Alissa Riker	*AR*	P	X	X	X								
31	Nilda Rodriguez	*NR*	A											
32	Matthew Sharp	*MS*	A											
33	Susan Shea	*SS*	P	X	X	X								
34	Mike Shriver	*MDS*	A											
35	Al Terrazas	*AT*	P	X	X	X								
36	Kelly Wallace	*KW*	P	X	X	X								
37	Eric Whitney	*EW*	P	X	X	X								
38	Mary Jane Wood	*MJW*	P	X	X	X								

(Attach. B#4)

HIV Health Services Planning Council
AIDS Office, Dept. Of Public Health
25 Van Ness Avenue, Suite 500
San Francisco, CA 94102-6033

Benjamin H. Staton
1594 Market St. Apt. 407
San Francisco, CA 94102

September 27, 1999

Council Members,

My name is Benjamin Howell Staton. I live at 1594 Market St., apt. 407, in the Catholic Charities run program known as Derek Silva Community. I am writing this letter because I feel my life is in jeopardy. On September 5, 1999, I had a heart attack. Concerned about my health, I dressed in shorts and a T-shirt and went down to the front desk of my building, reporting chest pain. The "Residential Counselor" on duty, called 911. The staff member reported that a man with chest pain was in need of assistance. **The staff also reported that this was a "residential facility for people with HIV."** The paramedics responding, (based on the information given to them by DSC staff), did not start an IV or administer Oxygen, nor did they take my blood pressure.

I believe I was "treated differently" as a direct result of the policies of Catholic Charities/Derek Silva Community. Catholic Charities/DSC violated my confidentiality and caused the quality of care I received from the emergency response staff to be less than superior. The paramedics asked me if it was "true that everyone living in this building has HIV?" I responded (while suffering my heart attack), that I would not disclose my neighbor's HIV status. I believe the emergency respond unit only needed to know that I had a chest port (central line), and that my Doctor, Virginia Cafaro attended at Davies Medical center. I do not believe the report of my status was within the responsibilities or the rights of the attending staff person. I did have a heart attack.

The next day, I called other members of the Tenants' Association from the CCU. I was curious to know if they were familiar with the policy regarding the disclosure of HIV status, over the telephone, in the common area of the lobby. The Co-chair of the Tenants' Association responded (on my behalf) by placing a call to Peter G. Veilleux, the Program Director of Derek Silva Community. Peter verbally responded by stating that the DPH had instructed the program to disclose our status with our names.

On my discharge day, my Cardiologist, Dr Tom Kaiser prescribed Zestril, and a long-acting Nitroglycerin for my angina, (I was awaiting heart surgery). My pharmacy delivered the medications at approximately 2:30 p.m. The front desk staff at D.S.C. did not notify me that my medications had arrived until **after 10:00 p.m.,** (placing my life in severe jeopardy).

How can an organization paid by the city and contracted for HIV Care Act funding, show so little concern and act so recklessly toward people with HIV?

I continue.

Approximately 4 years ago, I required hospice care, at the same address, under the care of my physician. I was on pain management 24 hours a day, 7 days a week (IV Dilaudid). I was undergoing 12 hours of TPN and another 8 hours of IV TB treatments. Catholic Charities/D.S.C. chose to disregard my Dr.'s recommendations. My doctor recommended that my domestic partner be allowed to remain with me in the evenings, 7 days a week. Catholic Charities/D.S.C. again disregarded my care and informed me that the "overnight guest policy" did not allow for extended visitation by anyone. My Doctor's and my personal requests were denied, leaving me in great danger of personal injury, (I still have the burned bed linens to prove it).

Are you starting to see a pattern here?

Last fall, the Chief Operations Officer of Catholic Charities, Sophie Lee Aldrich, did a sage burning (Feng Shui) ceremony outside my door. The sage started a fire on the carpeting leaving burns that had to be replaced. This does not strike me as prudent in an old (over 80-year-old) building constructed of wood and brick.

I have also had sexually inappropriate advances made by member of D.S.C. staff, (a Residential Counselor) as well as being sexually molested by the same staff member.

To the members of the HIV Health Services Planning Council:

I am not asking for any type of special treatment. I am a 35-year-old, Out, proud man living with HIV. I am asking you to rethink the logic that allows a historically homophobic institution to administer a great deal of the HIV housing contracts in the City of S.F. I believe if I were to pursue this case in a court of law, I could probably sue and prevail against Catholic Charities. However, the ALRP does not get involved in non-profit disputes. I have no choice but to come to you.

Please consider removing Catholic Charities from the HIV housing business. Repeatedly this institution has been "called on the carpet" for abusive, inappropriate care of people with HIV. Why do you continue funding an organization that harms people like me? I have survived nineteen years with HIV disease, a heart attack, a stroke, being raised in the homophobic deep south and Military School. My six years at D.S.C. have by far, been the most arduous process. Can anyone help me to get out of this program and still maintain a safe, clean, handicapped accessible, affordable, inexpensive living situation without having to live under the tyranny that is Catholic Charities? All legal referrals will be appreciated.

Benjamin Staton.

(Attach. B)

SAN FRANCISCO HIV HEALTH SERVICES PLANNING COUNCIL HOUSING COMMITTEE HOPWA POLICY RECOMMENDATIONS

September 27, 1999

During the prioritization for FY 2000-2001, the Housing Committee discussed a number of issues related to HOPWA (Housing Opportunities for People With AIDS), and is recommending the following:

1. The selection of a new Council representative to the HOPWA loan committee (Tom Calvanese and Ali Riker are the current representatives).
2. Clarification of the Council's role in the prioritization and allocation of HOPWA funds.
3. Enhanced consumer representation in the planning process for the use of HOPWA funds.
4. A detailed report from the SF Redevelopment Agency to the Council outlining the ways in which the uses of HOPWA funds, both former and proposed, are consistent with the Council's priorities.
5. Full utilization of all HOPWA funds budgeted for subsidies. HOPWA subsidy budget should not be decreased. HOPWA eligible CARE subsidy recipients be transferred to HOPWA subsidies, CARE subsidy funds be used for individuals ineligible for HOPWA.
6. Analyze calculation of number of HOPWA units in mixed housing developments based on up front HOPWA capital contribution to accurately reflect tenant rent contribution and ensure maximum number of HOPWA units
7. Make subsidies (including HOPWA subsidies) available outside San Francisco, within EMA.
8. Allow shared housing for HOPWA subsidy recipients.

HIV HEALTH SERVICES PLANNING COUNCIL

DOCUMENTS DEPT.

October 25, 1999 4:30 - 7:30 PM

OCT 21 1999

Room 201 - City Hall - 1 Dr. Carlton B. Goodlett Place

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Agenda

I.	Call to order	4:30 PM
II.	Roll Call	4:32 PM
III.	Review and Approval of Agenda	4:35 PM
IV.	Review and Approval of Minutes - 8/23 (carried over) & 9/27 - VOTE	4:37 PM
V.	General Announcements	4:45 PM
VI.	Public Comment	4:55 PM
VII.	Reports	
	• Mayor's Liaison - Bill Barnes	5:00 PM
	• Steering Committee Local elections & ethics Planning Council Support Quality of Care Assessment & Needs Assessment supplement Schedule Nov. & Dec. Council meetings	5:10 PM
	• AIDS Office	5:40 PM
	Break	6:00 PM
	• Grantee Assessment Task Force	6:15 PM
	• Evaluation & Implementation Committee	6:30 PM
	• Membership Committee Status of current appointment/reappointment requests New member orientation Overview of members' attendance requirements	6:45 PM
	• PWA Caucus Consumer Rights Advocacy Project update Community forum: Bayview-Hunters Point, 6:00 PM, October 22,1999	7:00 PM
	• Housing Committee	7:15 PM
VIII.	New Business	7:25 PM
IX.	Adjournment	7:30 PM

Upcoming meetings:

DATE	GROUP	PLACE	TIME
Monday, November 1	Eval. & Implementation	25 Van Ness, Room 330-B	5:00 - 7:00 PM
Monday, November 1	Membership Committee	25 Van Ness, Room 330-A	5:30 - 7:00 PM
Wednesday, November 3	Housing Committee	25 Van Ness, 5th flr - training rm A	4:00 - 6:00 PM
Wednesday, November 3	PWA Caucus	25 Van Ness, Room 330-B	5:30 - 7:00 PM
Monday, November 8	Steering Committee	25 Van Ness, 5th flr - Conf Rm	5:00 - 7:00 PM
Monday, November 15	Eval. & Implementation	25 Van Ness, Room 330-B	5:00 - 7:00 PM
Monday, November 29 (?)	Planning Council	City Hall, Room 201	4:30 - 7:30 PM

Minutes, October 25, 1999 HIV HEALTH SERVICES PLANNING COUNCIL

I. Call to Order
4:30 PM

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II. Roll Call
Attachment A, Column 1

III. Review and Approval of Agenda
Agenda accepted.

IV. Review and Approval of Minutes (VOTE)
8/23/99 (carried over) – Corrections made to voting error and minutes approved.
9/27/99 - Approved.

IV. General Announcements

- *VC* announced that a transgender was killed in King's Hotel fire.
- *MS* announced his resignation from Council.
- *LO'C* stated that *TL* is still sick at this time in Long Hospital. She is resigning the Council, though she plans to continue in PWA Caucus.
- *MM* announced his resignation from the Council.
- Member's address list was passed around to update.
- Job Announcements for Council Staff Coordinator and Clerical Support were distributed. [Attachment B]
- Current calendar was given out. [Attachment C]
- *SJ* announced that a reception for Diane Jones, Tom Calvanese, Will Carter and Nilda Rodriguez will be held on Tuesday, November 30, from 6:00 PM to 8:00 PM, at the AIDS Foundation Office, 995 Market St. at Sixth, second Floor Conference Room.
- *SJ* introduced *Father Nazarine* who works with men in jails.

V. Public Comments

- *Guy Vandenberg* spoke about public rumors and misunderstanding regarding the Medical Waiver Program. A Medical Waiver Program fact sheet was passed out to the Council. [Attachment D] *SS* stated that the Council is clear about the misunderstandings and the implementation task force addressed the issue of the medically indigent.
- *Father Nazarene* spoke about trying to gather concern for HIV positive prisoners in jails from the religious community. *VC* responded that she spoke with Sheriff Hennessey about starting a transition program for transgendered folks in prison. She reports that this might begin next month.

VI. Reports

VII. Mayor's Liaison

Bill Barnes introduced *Danielle Ducaine*, Assistant to the Mayor. He passed out an Ethics memo [Attachment E]. HRSA housing policy was discussed. It is unclear currently what this new policy will entail. He reports that the policy initially stated that HRSA would allow the city to do, as it will with funds, now it looks as if additional tasks would be tacked to the funding. This is in reference to SRO conditions for PWA/HIV in the city. The issue of the Mayor not making new appointments to the Council until after the elections was discussed. Current members are expected to serve for an indefinite period of time.

VIII. Steering Committee

EW presented:

Local Elections & Ethics

The Council is awaiting ethical documentation. It has to be clear that there are codes of ethics in official Council capacity that need to be abided by members in Council sessions. One of the codes of ethics is that Council members cannot endorse candidates or any electoral positions having to do with local elections. This includes campaign literature or asks for members to vote a certain way.

Planning Council Support

The Five-Year Work Plan for the Council needs members for strategizing the next five years of the Council. *EW* will be taking names and getting in touch with interested persons.

Quality of Care Assessment (Client Satisfaction Project) & Needs Assessment Supplement

$70,000 has been made available to do these Projects. The CARE Council Co-Chairs, the Support Center and others will examine what an independent Quality of Care project would entail, identifying that each Ryan White-funded agency is required to have such a tool in place for their programs. This year, until the end of February 2000 was the start-up phase. A group of Council members, community members, CARE contractors, AIDS Office staff members and others will put together a framework for the Quality of Care Assessment and Client Satisfaction survey that is replicable, and have a pilot run in February 2000. Harder & Co. and the Support Center have been re-enlisted to complete the initial surveying for the Needs Assessment that still has deficits which include, completing the number of Latino, Youth, MSM, and MSM/IDUs surveys that were not done. The number of surveys to be done is approximately 385 in San Francisco, then doing the analysis and write-up to augment the existing survey data. The Co-Chairs are meeting with the AIDS Office, San Francisco AIDS Foundation, and other policy makers to discuss the role of the CARE Council in the Ryan White CARE reauthorization. A sign-up sheet was passed out for this meeting. *EW* requested that members give him their email addresses so he could keep Council members updated on various Council items.

Scheduling for November & December Council Meetings

EW will request Harder & Co. to gather Council input to form their data analysis plan to finish the survey analysis at the December meeting. *EW* suggested that the date of the regular November meeting be changed. A vote was taken, for 11/22 – 12 persons, for 11/29 – 6 persons. The November Council meeting is 11/22/99. For the December meeting, the suggestion was for the Council to meet on Monday, December 6, rather than cancel and to dedicate time to the Grantee Assessment Presentation and the Data Analysis Planning with Harder & Co. Other committee meetings may be reschedule as needed. Due to time constraints there may not be enough time for committee reports, prioritization and budget reduction scenarios on this date. Monday, December 13 was an alternative date. *EW* will check to see if *Barbara Rosa* is available on December 13. *EW* spoke about the importance of members remaining on committees they join, since the committees need council support. *LG* reported that five meetings a quarter are a requirement for Council membership.

Timeline: 12/13 Harder & Co. Data Analysis Plan, Grantee Assessment presentation.
2/28 Start-Up Phase end. Survey Pilot started.

IX. AIDS Office

Michelle Long-Dixon presented the Second Quarterly Report and back-up document (Contract Status Report), fiscal year, March 1999 – February 2000. [Attachments F_1 to F_3] She reported that this is updated in terms of Action Taken. She requested more Council input for the budget planning process to have an idea of the Council's will on the projects. By the third quarter, the contracts should be

completed. Note that under "Estimated Unobligated Funds To Date", the date 8/25/99 should be 10/25/99. In discussion regarding Rollover or Carryover funds, *SS* asked *SO* that the Attachments F_1 to F_3 considerations be assigned to the Implementation & Evaluation committee next Monday. On a preview of the third Quarterly Report, *Michelle* reported that the items included calling on persons to assist on annual program monitoring activities, as well as technical assistance and capacity building work done by *Laura Thomas*. *Billy Pick* was given kudos for his work with the AIDS Office in getting funding for the Forensic AIDS Project. *VC* wanted to bring attention to case management for transgendered persons in jail from the Forensic AIDS Project. *SJ* said he would like to know jail methodology and transitional planning addressing ex-offenders medication and transitioning needs. *Michelle* reported that this is a concern at the AIDS Office and would like more Council input on this issue. *Laura* passed out an SFAIDS Foundation Action Alert Update regarding CARE Act Title I and Title III. [Attachment G]

X. Break

LO'C reported that she has information about a meeting on the issues of HIV + women, pregnancy and mandatory testing. If anyone is interested please contact her.

XI. Grantee Assessment Task Force

AM reported that the AIDS Office has a discussion copy of the Grantee Assessment Report (GAR). They are reviewing the document to develop a response. November 16th the AIDS Office will meet with the Implementation & Evaluation Committee, 3:00 PM – 5:00 PM to discuss their response.

Timeline: 11/16 AIDS Office response to GAR with E&I Committee
3:00 - 5:00 PM, 25 Van Ness, Room, Room 330-B

XII. Implementation & Evaluation Committee

GG reported that the original prioritization task force sub-structure is being used. The various task forces will only meet during the next two I&E Committee meetings. This is to assure that the tasks are completed and voted on by the Council's November 22 meeting. In the next two meetings the goals will be to complete work on reducing priorities, criteria of categories, and monetary shifts. Then the committee will address whether no action items are to remain priorities and be carried over or should be removed from the documents and rollover funding.

Timeline: 11/1 I&E Committee, 5:00 PM-7:00 PM, 25 Van Ness, Room 330-B
11/15 I&E Committee, 5:00 PM-7: 00 PM, 25 Van Ness, Room 330-B

XIII. Membership Committee

Status of Current Appointment/Reappointment requests

LG report that on 10/4/99 a letter was sent to the Mayor when the last candidate was appointed. To date 15 persons have been appointed without Mayor's approval. No new persons have been recommended. *SS* requests that the Membership Committee continue to submit names to Mayor's Office despite frustrations. *LG* reports that she was concerned that *Bill Barnes* requested that the Committee keep submitting names so that the Mayor's Office can pick between the incumbent members and the new candidates.

Timeline: 11/1 Membership Committee, 3:00 PM–5:00 PM, 25Van Ness, Room 330-A.

New Member Orientation

LG ask for more members to get involve in the New Members' Orientation. On 11/13, *LG*, *DB*, and *EW* will meet to formulate and agenda for the Orientation.

Timeline: 11/13 New Members' Orientation, 10:00 AM - 1:00PM, 25 Van Ness, Room 330-A

Overview of Members' Attendance Requirements

LG has been collating the Council's attendance record and membership expertise, with *Michael Moors'* assistance, to make sure that the Council is in compliance with the CARE Act.

XIV. PWA Caucus

Consumer Rights Advocacy Project

Richard Bargetto was introduced to the Council. The HIV Consumer Rights Advocacy Project brochure was passed out. [Attachment H] He has been investigating several complaints and will generate a report for the PWA Caucus meeting.

Community Forum: Bayview-Hunters Point, 6:00 PM, October 22, 1999

VC reported on the Community Forum. While small, the meeting was productive. *LO'C* reported that she was struck by the lack of services in Bayview-Hunters Point. There is a need for a follow-up meeting in the area. The next community forum is scheduled for January 2000, in the Mission District.

Timeline: 11/3 PWA Caucus, 5:30 - 7:30 PM, 25 Van Ness, Room 330-B

XV. Housing Committee

AR reported that the next Housing Committee is Wednesday, 11/3. *Hazel Betsey* has consented to co-chair the Housing Committee. The next meeting will focus on the work that came out of the I&E Committee on Housing, to determine where recommendations for prioritization need to be made. The Windsor Hotel is having an Open House, 10/28. Although not CARE funded, it is a model for master leasing SRO.

Timeline: 10/28 Windsor Hotel Open House, 11:30 AM - 1:30 PM, 238 Eddy Street.

XVI. New Business

- *SJ* reminded members to make certain that they update the Members Address List so that invitations to the 11/30 Reception are sent to the correct addresses.
- *LG* wants the Council to place Immigrant issues on prioritization task list.
- *VC* announced that there is a new Transgender Task Force being formed by Supervisor Mark Leno, she asked members who know of any transgender persons working in their community to forward their names to her.
- At the Bayview-Hunters Point community forum there was a membership drive. The council needs to make certain that when they return to the community membership applications are made available.

IX. Adjournment

7:15 PM

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HIV Services Planning Council

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Votes [2-4]: **Y**=Yes; **N**=No; **B**=Abstain

8/23/99		[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
1. Alliena Baker	*AB*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Kirsten Balano	*KB*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3. Hazel Betsey	*HB*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4. Donald Bliss	*DCB*	P	B	Y	Y	Y	Y	Y	Y	Y	Y	Y	B
5. Jeff Byers	*JB*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6. Tom Calvanese	*TC*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
7. Bart Casimir	*BC*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8. Veronika Cauley	*VC*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9. Julie Charubusapayon	*JAC*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10. Raymond Combs	*RC*	P		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
11. John Conley	*JC*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
12. Luis De La Torre	*LDT*	P	B	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13. Mark Dunlop	*MD*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
14. Gregory Edwards	*GE*	A											
15. Gene Gowdey	*GG*	A											
16. Laura C. Guzman	*LCG*	A											
17. Siddiq Jihad	*SJ*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18. Diane Jones	*DJ*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
19. Sam Kaplan	*SK*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
20. Tony Leone	*TL*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
21. Gene London	*GL*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
22. Allen Meyer	*AM*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
23. Jim Mitulski	*JM*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
24. Lee Ann Monfredini	*LM*	A											
25. Norm Nickens	*NN*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
26. Lisa O'Connor	*LO'C*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
27. Loras Ojeda	*LO*	A											
28. Jorge Ortiz	*JO*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
29. Stephan Oxendine	*SO*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
30. Ken Pearce	*KP*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
31. Alissa Riker	*AR*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
32. Nilda Rodriguez	*NR*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
33. Matthew Sharp	*MS*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
34. Susan Shea	*SS*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
35. Mike Shriver	*MDS*	P			Y	Y	Y	Y	Y	Y	Y	Y	Y
36. Al Terrazas	*AT*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
37. Kelly Wallace	*KW*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
38. Eric Whitney	*EW*	P	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
39. Mary Jane Wood	*MJW*	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

attach: B

San Francisco HIV Health Services Planning Council

Job Announcement

The San Francisco HIV Health Services Planning Council is seeking applicants for a consultant position to act as *Council Staff Coordinator* (see attached job description).

Please submit letter of intent and resume to:

HIV Health Services Planning Council
c/o Richard Bargetto
1540 Market Street #301
San Francisco, CA 94102
Attention: Council Co-chairs

Applications may be faxed to 415-863-0831

Deadline for submission: Friday, October 29, 1999

Please call Michael Moors at 415-863-5462 with questions or for additional information.

SF HIV Health Services Planning Council

Clerical Support Consultant Job Description

The HIV Health Services Planning Council is seeking to hire an individual to act as Clerical Support Consultant, to assist the Council in its planning activities by performing clerical and logistical support for the Council. This individual should possess strong writing, organizational, and communication skills and will be responsible for the following:

1. The Clerical Support Consultant will ensure the recording of Council, Committee, Caucus and Task Force meetings, as well as any Community Outreach meetings, and other special meetings, as necessary.

2. The Clerical Support Consultant will coordinate the provision of refreshments at Council meetings, PWA Caucus meetings, and Community Outreach meetings.

3. The Clerical Support Consultant will assist in the preparation of regular mailings to the Council, containing Committee Reports and Agendas, Council Minutes and Agendas, and additional requests for information from the Council, its Committees, Task Forces and Caucus.

4. The Clerical Support Consultant will communicate closely with the Staff Coordinator, will be evaluated by the Council co-chairs, and will make reports to the Steering Committee, and to the full Council, as needed.

5. The Clerical Support Consultant will be employed as an independent consultant, under a Memorandum of Understanding (MOU) with the Support Center for Nonprofit Management, based on the Planning Council Support Contract with the Support Center for Nonprofit Management.

6. The Clerical Support Consultant will be reimbursed at the the rate of $20 per hour, and will invoice the Support Center semi-monthly, at a rate not to exceed 20 hours per week, as per the Planning Council Support Contract.

7. The Clerical Support Consultant shall perform other tasks, as needed, and identified by the Council's Steering Committee.

San Francisco HIV Health Services Planning Council

Job Announcement

The San Francisco HIV Health Services Planning Council is seeking applicants for a consultant position to act as *Clerical Support Consultant* (see attached job description).

Please submit letter of intent and resume to:

HIV Health Services Planning Council
1540 Market Street #301
San Francisco, CA 94102
Attention: Council Co-chairs

Applications may be faxed to 415-863-0831

Deadline for submission: open

Please call the HIV Health Services Planning Council office at 415-863-0831 with questions or for additional information.

SF HIV Health Services Planning Council

Staff Coordinator Job Description

The HIV Health Services Planning Council is seeking to hire an individual to act as Staff Coordinator, to assist the Council in its planning activities by coordinating administrative, clerical and logistical support for the Council. This individual should possess strong organizational and communication skills and will be responsible for the following:

1. The Staff Coordinator will coordinate the work of Clerical Support Staff to ensure the recording of Council, Committee, Caucus and Task Force meetings, as well as any Community Outreach meetings, and other special meetings, as necessary.

2. The Staff Coordinator will coordinate the provision of refreshments at Council meetings, PWA Caucus meetings, and Community Outreach meetings.

3. The Staff Coordinator will be responsible for the coordination of regular mailings to the Council, containing Committee Reports and Agendas, Council Minutes and Agendas, and additional requests for information from the Council, its Committees, Task Forces and Caucus.

4. The Staff Coordinator will be responsible for the implementation of other Council initiatives, such as the HIV Consumer Rights Advocacy Project, Technical Assistance Consultants, and other consultants, as determined by the Council.

5. The Staff Coordinator will communicate closely with the Council Co-chairs, will be evaluated by them, and will make monthly reports to the Steering Committee, and to the full Council, as needed.

6. The Staff Coordinator will be employed as an independent consultant, under an MOU with the Support Center for Nonprofit Management, based on the Planning Council Support Contract with the Support Center for Nonprofit Management.

7. The Staff Coordinator will be reimbursed at the the rate of $25 per hour, and will invoice the Support Center semi-monthly, at a rate not to exceed 20 hours per week, as per the Planning Council Support Contract.

8. The Staff Coordinator shall perform other tasks, as needed, and identified by the Council's Steering Committee, and will attend monthly Steering Committee meetings.

San Francisco HIV Health Services Planning Council

Job Announcement

The San Francisco HIV Health Services Planning Council is seeking applicants for a consultant position to act as *Clerical Support Consultant* (see attached job description).

Please submit letter of intent and resume to:

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1540 Market Street #301
San Francisco, CA 94102
Attention: Council Co-chairs

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Exhibit B

Continuum HIV Day Services

MediCal Waiver Program

Fact Sheet

Services:

Clients who are enrolled in this program will receive case management and additional home care services from a team of professionals including a social worker: Paul Erickson, MSW and a nurse: Ingrid Nelson, RN, ANP.

Each client will be eligible for a range of services including (but not limited to) attendant care, homemaker support, skilled nursing visits, occupational and/or physical therapy visits, nutritional support and outpatient psychotherapy. The total amount of funding available for these services is $13,902 *per client/per year*.

Eligibility:

We are able to offer these services to clients who meet the following eligibility criteria:

- HIV symptomatic
- Documented Karnofski score of 60 or below
- Documented need for Nursing Facility Level of Care.

A Karnofski tool and an explanation for what constitutes a "Nursing Facility level of care" are attached. Please note that Residential Care Facilities (such as Maitri Hospice, the Peter Claver Community and the Cohen Residence) are not considered Nursing Facilities and therefore clients who live in these facilities may still be eligible for our program.

Enrollment:

We are currently compiling a waiting list for the program and would be happy to accept your referrals. If you are a provider wishing to enroll a client, please complete the attached form and fax or send to the address listed at the bottom of the page.
Call 437-2900, extension 126 to obtain information about the status of your referrals and about the current waiting list.

Caseload:

The total caseload for this program will be 30 clients for now, but this may be expanded to 45 by the end of 1999 as additional funding becomes available and additional staff will be hired. Further expansion of the caseload requires approval from the State Office of AIDS and is based on need (i.e.: length of waiting list). Case-slots are also currently available in the MediCal Waiver Program of Westside Community Mental Health.

Funding:

The program is funded by the State of California Department of Health Services, through the Community Based Care Section of the Office of AIDS.

Please feel free to contact Guy Vandenberg at 437-2900, extension 103 if you have any questions about the program.

NURSING FACILITY (NF) LEVEL OF CARE

The NF Level of Care Criteria, as defined by Title 22, California Code of Regulations, Section 51334, paragraph (l), states:

"In order to qualify for nursing facility care services, a client may have at least a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. NF care services at a minimum emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual client independence to the extent of his/her ability. As a guide for determining appropriate placement:

1. The complexity of the client's medical problems is such that he/she requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet his/her health needs.

2. Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis.

3. Diet may be of a special type and client may need assistance in feeding him/herself.

4. The client may require assistance or supervision in personal care, such as in bathing or dressing.

5. The client may need encouragement in restorative measures for increasing and strengthening his/her functional capacity to work toward greater independence.

6. The client may have some degree of vision, hearing or sensory loss.

7. The client may have limitation in movement.

8. The client may be incontinent of urine and/or bowels.

9. The client may exhibit some mild confusion or depression; however, his/her behavior must be stabilized to such an extent that it poses no threat to him/herself or others."

NURSING FACILITY (NF) LEVEL OF CARE

The NF Level of Care Criteria, as defined by Title 22, California Code of Regulations, Section 51334, paragraph (l), states:

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9. The client may exhibit some mild confusion or depression; however, his/her behavior must be stabilized to such an extent that it poses no threat to him/herself or others."

Referral for MediCal Waiver Program

(Dear Provider: This is THE ONLY FORM you have to complete to enroll a patient!!)

Client Name: _____ D.O.B._____
Last Name First Name Middle Initial

Is a patient who is currently under my care and who has:

1. A Karnofski Status Rating of : _____
(NOTE SCORE MUST BE 60 OR LESS TO QUALIFY)

2. A need for a Nursing Facility Level of Care (as defined by the State of California Office of AIDS).

3. A diagnosis of disabling HIV disease or AIDS.

Name of Primary Care Provider: _____

Affiliation or Address: _____

Signature/Date: _____ MD / NP / PA / DO
(Please Circle)

Person Initiating This Referral (Case Mgr., SW, RN)_____

Agency_____ Phone_____

Please Send or Fax Completed Referral Form to: ***Continuum HIV Day Services,***
255 Golden Gate Avenue
San Francisco, CA 94102
FAX: (415) 437-2550
ATTN: Pam Sandvand

We will keep you informed about your patient's place on our waiting list and of the anticipated enrollment date. Please call Ingrid Nelson (x125) or Paul Erickson (x126) if you have any questions: (415) 437-2900.

Karnofsky Evaluation Tool For Persons With HIV Disease/ AIDS

AREAS ASSESSED	DATE ASSESSED/INITIALS							
1. NUTRITION INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1								
2. HYGIENE INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1								
3. EXCRETION INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1								
4. ACTIVITY INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1								
5. TREATMENT/MEDICATION INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1								
6. TEACHING INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1								
7. SUPPORT SYSTEMS INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1								
8. MENTAL STATUS INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1								
9 BEHAVIOR INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1								
TOTAL RATING								

CLIENT NAME: _____ FILE NUMBER: _____

attach: E

OFFICE OF THE MAYOR
SAN FRANCISCO

WILLIE LEWIS BROWN, JR.

MEMORANDUM

To: Members, San Francisco HIV Health Services Planning Council

From: Bill Barnes, Advisor to the Mayor on AIDS and HIV Policy

Date: October 25, 1999

Re: Response to Request for Information from the San Francisco HIV Health Services Planning Council Steering Committee

---

At yesterday's meeting of the HIV Health Services Planning Council's Steering Committee, I agreed to a number of requests to communicate with council members directly to help clarify important policy issues about the appropriate roles of council members.

As I stated at the Steering Committee meeting, abiding by the laws, rules and regulations of the City and County of San Francisco is expected for members serving in official capacities on advisory bodies, and Mayor Brown certainly holds this expectation for his appointees. Understanding these policies and procedures remains the responsibility of appointees.

Concerns were raised about the political participation of council members, particularly as we approach the election. In July, the Ethics Commission circulated a memo to all department heads and board and commission members about the appropriate nature of political activities. I am unclear why members of these two bodies did not receive them, and have attached the memo for your review. Of particular interest to council members is Section I, which states explicitly that "City officers and employees may not engage in political activities while on duty and may not use city resources, such as photocopy or fax machines for political activities." For additional clarification, please contact Deputy City Attorney Claire Sylvia at (415) 554-4706 or the San Francisco Ethics Commission at (415) 554-9510.

If you have any questions or if I can be of additional assistance on these or other matters, please call me directly at (415) 554-5101.

MAYOR'S OFFICE OF AIDS & HIV POLICY
CITY HALL—ONE DR. CARLTON B. GOODLETT PLACE, ROOM 476, SAN FRANCISCO, CALIFORNIA 94102
(415) 554-6960, FAX (415) 554-6965
RECYCLED PAPER

ETHICS COMMISSION
CITY AND COUNTY OF SAN FRANCISCO

ISABELLA H. GRANT
CHAIRPERSON

HENRI E. NORRIS
VICE-CHAIRPERSON

ROBERT D. DOCKENDORFF
COMMISSIONER

CAROL M. KINGSLEY
COMMISSIONER

PAUL H. MELBOSTAD
COMMISSIONER

VIRGINIA E. VIDA
EXECUTIVE DIRECTOR

Date: July 28, 1999

To: All Department Heads
All Board and Commission Members

From: Ginny Vida G.V.
Executive Director

Re; ELECTION-RELATED ACTIVITIES

As the November election draws near, the Ethics Commission has received a number of inquiries about the rules that govern the conduct of City officers and employees who wish to engage in election-related activity. This memorandum sets forth some general guidelines. The memorandum is intended only as a general guide and does not constitute legal advice about a particular course of conduct. If you have questions about a specific course of conduct, please contact the Ethics Commission at (415) 554-9510 or Deputy City Attorney Claire Sylvia at (415) 554-4706.

I. Use of City Resources

It is unlawful for City officers or employees to use public resources or personnel to engage in political activity relating to elective offices and ballot measures at the federal, state and local level. City officers and employees may not engage in political activities while on duty and may not use city resources, such as photocopy or fax machines for political activities. The ban on engaging in political activity while on duty prohibits such activities as circulating petitions, addressing envelopes or engaging in any other political activities that use City resources or divert you from your assigned duties.

Considerable penalties may be imposed for violation of these rules. Misappropriation of public funds is a felony punishable by imprisonment for two, three, or four years, and may result in a bar from holding public office in the state. Use of City funds for political or election activities also may be deemed official misconduct that justifies removal of a public officer or provides cause to fire a public employee.

II. Off-Duty Political Activities by City Officers and Employees

City officers and employees generally have a First Amendment right to engage in political activities while off duty. Nevertheless, certain restrictions on political activity apply even off-duty. Officers and employees may not directly or indirectly solicit funds from other officers or employees of their local agency or from persons on employment

1390 Market Street, Suite 801 • San Francisco, CA 94102-5302 • Phone (415) 554-9510 • Fax (415) 554-8757
E-Mail Address: ethics_commission@ci.sf.ca.us Web site: http://www.ci.sf.ca.us/ethics/

lists of the local agency. (*See* Govt. Code §3205.) In addition, officers and employees of local agencies may not participate in political activities of any kind while in uniform. (*See* Govt. Code §3206.)

City officers and employees may not use their official positions to influence elections. For example, a board or commission may not vote to endorse a measure or a candidate, and a City official may not distribute campaign literature along with official forms. This prohibition does not affect the ability of individual officers and employees to take a public position on an electoral race or a ballot measure. In addition, acting as private citizens, City commissioners, and other officers and employees may endorse candidates or measures even where the commission as a group may not.

III. Solicitation or Acceptance of Campaign Contributions by Appointed Board Members

Members of appointed boards and commissions may not solicit, accept or direct campaign contributions of more than $250 from any party or participant in any use entitlement proceeding pending before the board or commission, during the proceeding or for three months after the final decision is rendered in the proceeding. (*See* Govt. Code §84308(b).) This rule applies whether the contributions are sought for the official or for someone else, and whether the contributions come directly from the party or participant, or are made by an agent acting on behalf of the party or participant. (*Id.*) For purposes of section 84308, contributions include contributions for candidates or committees in federal, state, or local elections. (*See* Govt. Code §84308(a)(6).) Section 84308 also requires a member of an appointed board or commission to disqualify himself or herself from any participation in any use entitlement proceeding involving a party or participant (or their agent) from whom the official received a contribution of more than $250 in the 12 months prior to the proceeding. (*See* Govt. Code §84308(c).) The $250 threshold applies to the combined total of all contributions from the party or participant and from an agent of the party or participant.

IV. Other Prohibited Election-Related Activity

State law also prohibits certain activities related to the gathering of petition signatures. In particular, no person may threaten to harm a person circulating a petition or the petition circulator's family with the intent to dissuade the petition circulator from circulating the petition or in retaliation for circulating the petition. (*See* Cal. Elec. Code §18630.) Nor may any person threaten to harm a petition circulator's property or the property of the petition circulator's family with the intent to dissuade the petition circulator from circulating the petition. (*Id.*) State law also prohibits taking a petition from a petition circulator by force. (*See* Cal. Elec. Code § 18631.) A violation of these provisions is a misdemeanor.

If you have any additional questions, please contact the Ethics Commission at (415) 554-9510.

attach: F1

HIV Health Services
2nd Quarterly Report to the HIV Health Services Planning Council
October 25, 1999

IMPLEMENTATION PLAN UPDATE

Attached is a revised copy of the 1999-00 Implementation Plan. It is condensed and organized into the following sections: *Projects Completed, Ongoing Projects, Projects, No Action Taken - No Additional Funds Allocated, No Action Taken, and No Action Taken - Unfeasible.*

Based on 107 suggested projects for a multi-year period, the categorical breakdown to date is as follows:

Projects Completed	22%	(24)
Ongoing Projects	34%	(36)
Projects, No Action Taken - No Additional Funds Allocated	37%	(40)
No Action Taken	5%	(5)
No Action Taken - Unfeasible	2%	(2)

The categorical percentages have not changes from the first quarter. HIV Health Services (HHS) staff continue to work on the ongoing projects. We have taken a deeper look at those projects in the categories of *No Action Taken - No Additional Funds Allocated* and *No Action Taken* to determine next steps and additional information needed should implementation become feasible or funding made available to proceed.

In prioritization for 2000-01, consideration should be given to projects in the categories of *Ongoing Projects*; *No Action Taken - No Additional Funds Allocated* and *No Action Taken* to determine whether they should be continued, redirected or discontinued with realistic timeframes established.

CONTRACT STATUS REPORT

For the 1999-00 grant period, 3/1/99 through 2/29/00, 85 CARE contracts and MOUs (Titles I and II) and 125 exhibits are being developed and processed. Current contract status as of 8/25/99 is as follows:

Certified	94%	(80)
In Review/Negotiation Process	6%	(5)

ESTIMATED UNOBLIGATED FUNDS TO DATE

The unobligated balance for 1999-00 as of ~~8~~ 10/25/99 = **$218,864**

This balance may increase or decrease as a result of continuing contract negotiations. Discussion should occur in the Evaluation & Implementation Committee regarding appropriate one-time use of these funds.

ACTIVITIES RESULTING FROM 1998-99 CARRYFORWARD FUNDS

Attached is the list of carryforward requests in priority order as presented to HRSA for review and approval. Those requests with an asterisk (*) were subsequently denied by HRSA, resulting in a final award of $1,598,215 in carryforward funds granted, to be expended by 2/29/00. Also indicated on the list is the action to be taken toward implementation of the project or allocation of the funds to the appropriate provider and the HHS Program Manager(s) assigned to each task.

PREVIEW OF 3rd QUARTER ACTIVITIES & UPDATES

- The HIV Health Services section has begun the Annual Program Monitoring activities. HIV Health Services Planning Council members are included in the database of community experts and may be invited to participate in the process.

- Jail initiative: Coordinated by Billy Pick, HHS applied for and received funding (CDC/HRSA with SPNS) with the State Office of AIDS for a collaborative 3 year project for Intervention, Prevention and Continuity of care for incarcerated individuals within correctional settings and the community. The SFDPH, HIV Prevention section, the Forensic AIDS Project and Centerforce in Los Angeles are included in this collaboration. This funding, in the amount of $500,000, will support our CBC effort of transitional case management for African Americans in prisons as well as the efforts of the Forensic AIDS Project in the jails and Prevention case management and risk reduction counseling efforts.

- Technical Assistance and Capacity Building: Coordinated by Laura Thomas, HHS applied to the Office of Minority Health for funding to support a project to provide technical assistance and organizational capacity building to community of color based organizations within the EMA. Unfortunately, although the proposal was approved, it did not receive a sufficiently high priority score to be supported with the limited funds available. The application submitted was for $1,200,000. Should more funds become available, we will be reconsidered.

attach : F2

HIV Health Services Implementation Plan
(Beginning 1999-2000: Multi-Year)

Created
11/19/98
Revised 10/25/99
(Includes project updates)

This implementation plan incorporates the program changes proposed by the HIV Health Services Planning Council during its prioritization process for 1999-2000 funding as well as projects proposed by the grantee for the same period.

Key to Symbols:

(-) To be achieved if funding is decreased
(=) To be achieved if funding is level
(+) To be achieved if funding is increased
(UX) To be achieved if unexpended funds are available

PROJECTS COMPLETED

Health Care

Sub-category: Primary Care

1. Develop standards of care for provision of Primary Care services to persons with HIV/AIDS (=) **DONE – NIH guidelines; compliance w/JCAHO standards**

2. Implement the standards of care in all funded services (=)
DONE – NIH guidelines made available; compliance w/such in directives required in 1999-00 contracts

4. To include adherence to treatment as an impact/outcome objective in CARE funded services contracts (=,+) **Included where appropriate; contractors informed of this requirement at the beginning of the contracting cycle**

5. To expand the integrated service model of care to include more services for African Americans, Latinos, and the incarcerated/newly released population. Services should be expanded by scope and sites of access (=,+) **Done for African American population through CBC initiative; to be expanded to Latinos through use of unobligated funds**

Sub-category: Home Health: Home-based

1. To provide in-home outreach and education to support adherence to multi-drug antiretroviral combination therapies (+) **INCLUDED IN CONTRACT LANGUAGE**

Sub-category: Home Health: Residential Facility-Based

1. Conduct an evaluation of the utilization of services within this subcategory, especially infusion and home hospice care, and redirect funds if the services are not being utilized at an appropriate level (=,+) **DONE**

2. To reorganize services/contracts so that residential facilities have direct control over home health care provided at their facilities. (=,+) **DONE**

Case Management

Sub-Category: Case Management

4. Increase availability of case management services after hours and on the weekend (+) **NO ADDITIONAL $; SOME CONTRACTORS HAVE EXPANDED HOURS**

5. Make available more vouchers for transportation and household goods (UX) **DONE**

Client Advocacy

Sub-category: **Treatment Advocacy**

3. Link to case management (=) **DONE**

Sub-category: **Money Management**

1. Include in integrated service models (=) **LINKED THROUGH HOUSING**

Direct Financial Emergency Assistance

Sub-category: **Direct Financial Emergency Assistance**

1. To relax the eligibility restrictions on the types of needs that can be covered under this service (=) **DONE**

Day/Respite/Childcare

Sub-category: **Children's Programs and Childcare**

2. To increase childcare access and flexibility, including on-call childcare (=,+) **INCREASED CAPACITY OF PROVIDER**

5. To make available more vouchers for transportation (UX) **DONE**

Housing

Subcategory: **Emergency Housing**

2. Link emergency housing to integrated services networks and to mobile Case Management and Peer Advocacy Models (=,+) **DONE**

3. To provide short-term storage facilities for homeless PWA or those residing in emergency housing (+) **INCLUDED IN ACTION POINT CENTER (OPENED 7/99)**

Sub-Category: **Housing Subsidies: Full and Shallow**

3. To conduct an evaluation of the utilization of services within this sub category, and redirect funds to emergency housing if the services are not being utilized at an appropriate level (=,+) **DONE**

5. To increase decentralized access to housing subsidies through the integrated services network and to mobile Case Management and Peer Advocacy models (=,+) **DONE**

Sub-Category: **Residential Hospice**

2. Re-evaluate residential hospice versus home health categories (=) **DONE**

Mental Health

Sub-Category: Long/short Term MH Services (Outpatient)

2. To support better integration of funding sources - including shifting CARE support services and clients to Medi-Cal support when feasible (=,+) **DONE**

4. Cut services for the severely mentally ill and transition clients to CMHS supported services (-) **DONE**

5. Evaluate reimbursement cap for services in order to make comparable to Medi-Cal rates (-) **DONE; MEDI-CAL RATES WERE CLOSE TO CARE RATES**

8. To conduct an evaluation of the utilization of services within this subcategory and redirect funds if the services are not being utilized at an appropriate level (=) **DONE**

Substance Abuse

Sub-Category: Residential Long-term

1. Combine with residential short-term category and create variable length of stay services, with analysis of need, and limit based utilization (=) **DONE**

ONGOING PROJECTS

Health Care

Sub-category: Primary Care

3. To evaluate changes in the provision of primary care and include an impact/outcome analysis component in the contractual scope of work (=,+) **Impact/outcome analysis included in contractual scope of work**

7. Integrate the availability of Action Point Adherence Centers (APAC) into the models of integrated service provision (=,-) **First Action Point Center opened 7/99**

Sub-category: Home Health: Home-based

3. To conduct an evaluation of the utilization of services in this subcategory and redirect funds if the services are not being utilized at an appropriate level. (=,+) **BEGINNING THIS YEAR CONTRACTORS HAVE BEEN ALLOWED TO REDISTRIBUTE FUNDS IN THIS CATEGORY BASED ON CHANGING UTILIZATION PATTERNS**

Case Management

Sub-Category: Case Management

1. Evaluate changes in the provision of case management and include an impact/outcome analysis component (-) **ONGOING – STANDARDIZED LANGUAGE RE: EXPECTED IMPACT/OUTCOME INCLUDED IN 1999-00 CONTRACTS; DATE FOR MTG W/ CM SCHEDULED FOR AUG 1999**

2. To achieve greater integration with client advocacy (=) **ONGOING THROUGH CONTRACT NEGOTIATION; BENEFITS COUNSELORS ARE OUTSTATIONED AT AGENCIES THAT ALSO PROVIDE CASE MGMT SVCS AS WELL AS INTEGRATED PROVIDER SITES**

6. Provide more training in case management standards (UX) **IN PROGRESS; DATE TBD**

7. Provide training in harm reduction principles (UX) **WORKSHOP CONDUCTED BY CSAS IN APRIL 1999; CATEGORICAL POSITION PAPER TBD**

Sub-category: Peer Advocate Outreach

1. Evaluate changes in the provision of peer advocacy services and include an impact/outcome analysis component and an analysis of the cost effectiveness of the model, returning funding to the Buddy/Companion category, if appropriate (=) **ONGOING; MTG W/PEER ADVOCATES SCHEDULED FOR AUG 1999**

3. To increase availability of peer advocacy services after hours and on the weekend (+)**NO ADDITIONAL S; SOME CONTRACTORS HAVE EXPANDED HOURS**

Client Advocacy

Sub-category: **Treatment Advocacy**

6. To provide training for treatment advocates (UX) **ONGOING THROUGH TREATMENT EDUCATION AND CERTIFICATION PROGRAM**

Sub-category: **Benefits Counseling**

1. Link to case management services (=) **ONGOING THROUGH CONTRACT NEGOTIATION**

Sub-category: **Legal/Immigration Assistance**

1. Link to case management services (=) **ONGOING THROUGH CONTRACT NEGOTIATION**

Direct Financial Emergency Assistance

Sub-category: **Direct Financial Emergency Assistance**

2. To decentralize access to direct financial emergency assistance (=)**ONGOING**

3. Develop a short-term eviction prevention program (=,+) **TO BE CREATED W/UNLIQUIDATED FUNDS**

4. To create access to direct financial emergency assistance services for the recently incarcerated/released (=,+) **NEED TO DEVELOP MOU BETWEEN CBC PROVIDER AND DIRECT FINANCIAL EMERGENCY ASSISTANCE PROVIDER**

5. To increase the annual financial limit per client for direct financial emergency assistance (+) **ONE TIME INCREASE THROUGH USE OF UNLIQUIDATED FUNDS FROM 1998-99.**

Food

Sub-category: **Food Bank /Meal Delivery**

1. To provide more complete nutrition/meals for the homebound (+) **NO ADDITIONALS; AGENCY NEEDS ASSESSMENT COMPLETED 6/99 OR 7/99**

Day/Respite/Childcare

Sub-category: **Children's Programs and Childcare**

1. Develop a site-based childcare program (=,+) **ONGOING; ADDITIONAL FUNDS TO BE ALLOCATED THROUGH USE OF UNALLOCATED FUNDS FROM 1998-99; ADDITIONAL ASSESSMENT NEEDED**

Program Support

Sub-category: Technical Assistance

1. To provide technical assistance and training for CBOs (+,UX) **ONGOING; RFP TBD; ADDITIONAL TRAINING TO BE PROVIDED THROUGH USE OF UNLIQUIDATED FUNDS FROM 1998-99.**

Sub-category: REGGIE/ACE

1. To purchase equipment (including computers) for agencies participating in REGGIE (=) **ONGOING**

Transportation

Sub-category: Transportation

3. To investigate the development of a contract with one or more taxi companies to provide transportation for PWAs (=,+) **ONGOING**

Overall

1. Develop an ongoing educational media outreach campaign about available services (=,+)**TO BE DEVELOPED THROUGH USE OF UNLIQUIDATED FUNDS FROM 1998-99.**

2. Incorporate harm reduction principles across all service categories to make services more accessible to active users (=,+) **NO ADDITIONAL $; INCORPORATED INTO 1999-00 CONTRACTS**

Housing

Subcategory: Emergency Housing

1. To expand decentralized access to emergency housing vouchers and shallow rent subsidies through linkages with expanded integrated service networks and at drop-in centers (=,+) **ADDITIONAL $ FOR EMERGENCY HOUSING VOUCHERS REQUESTED FROM UNLIQUIDATED FUNDS FROM 1998-99**

4. Fund more emergency housing vouchers (UX) **ADDITIONAL $ FOR EMERGENCY HOUSING VOUCHERS REQUESTED FROM UNLIQUIDATED FUNDS FROM 1998-99**

Sub-Category: Housing Subsidies: Full and Shallow

1. To create a reserve fund for minor repairs to units damaged by subsidy tenants (=, +) **NO ADDITIONAL FUNDS; ADDITIONAL $ FOR APPLIANCE REPLACEMENT REQUESTED FROM UNLIQUIDATED FUNDS FROM 1998-99**

Sub-Category: **Transitional Housing**

1. To increase decentralized access to transition housing through the integrated service networks and to mobile Case Management and Peer Advocacy models (=,+) **NO ADDITIONAL $; FURTHER ANALYSIS NEEDED**

2. To investigate master leasing of buildings, sublet with support services (=,+); **ONGOING**

Sub-Category: **Practical Support**

1. Insure that practical support services are provided within housing facilities, especially within SRO emergency housing (=) **ASSESSMENT ONGOING THROUGH SPECIFICATION OF PRACTICAL SUPPORT TIME IN CONTRACTS**

Mental Health

Sub-Category: **Long/short Term MH Services (Outpatient)**

1. To create better integration with other services, including the integrated service networks (=,+) **ONGOING; HELD MEETINGS WITH ISP & MH & SA PROVIDERS – DEMONSTRATED IMPROVEMENT OF LINKAGES NOT ACHIEVED**

Sub-category: **Residential Care**

2. Provide training for service providers on dementia/cognitive impairment (+) **TO BE CONDUCTED WITH UNLIQUIDATED FUNDS FROM 1998-99**

Substance Abuse

Sub-Category: **Residential Long-term**

2. To provide training for service providers on integrating harm reduction principles into service provision (=,UX) **WORKSHOP CONDUCTED BY CSAS IN APRIL; ADDITIONAL TRAINING UNDER CONSIDERATION; NO ADDITIONAL $**

4. To create better linkages of providers into networks of care (=) **ONGOING; HELD MEETINGS WITH ISP, MH, AND SA PROVIDERS - DEMONSTRATED IMPROVEMENT OF LINKAGES NOT ACHIEVED**

Sub-Category: **Residential Short Term**

3. To encourage more linkages between jail and community-based services (=,+) **INCORPORATED INTO SOME CONTRACTS; AO APPLYING FOR ADDITIONAL GRANT $; WILL OCCUR FOR AA/LATINO COMMUNITIES THROUGH CBC PROJECT**

5. To provide furnishings for residential programs (UX) **ADDITIONAL $ FOR APPLIANCE REPLACEMENT REQUESTED FROM UNLIQUIDATED FUNDS FROM 1998-99**

Sub-Category: Overall

1. To coordinate substance abuse services across funding streams - working with CSAS' Treatment on Demand to leverage services, combine services, combine funding streams, and plan for the system as a whole. Linkages should be made to housing and other services funded elsewhere (especially youth services) (=,-,+) **NO ADDITIONAL $; JOINT COUNCIL COMMITTEE CONTINUES TO MEET; NEED FOR ADDITIONAL COLLABORATION BETWEEN DPH SECTIONS (AO/CSAS)**

NO ACTION TAKEN - NO ADDITIONAL FUNDS ALLOCATED

Health Care

Sub-category: Primary Care

6. Develop drop-in centers for primary care services (+) **NO ADDITIONAL $**

Sub-category: Dental

1. Evaluate the need for and potential capacity to include dental services within the integrated model of care (=,+); **NO EVAL CONDUCTED – New Dental model created for 98-99; NO ADDITIONAL $. The following assessment needs to occur prior to the allocation of new funding: Do Integrated Service providers (ISP) refer clients to CARE funded dental services? Can the dental providers identify clients referred from ISP? Since the creation of the decentralized dental services, is it easier for clients to receive services? Is further expansion of services necessary?**

Sub-category: Pharmaceuticals

1. Evaluate the need for and potential capacity to include pharmaceutical services within the integrated model of care (=,+) **NO EVAL CONDUCTED; NO ADDITIONAL $**

Sub-category: Complementary Therapy

1. Evaluate the need for and potential capacity to include complementary treatment services within the integrated model of care (=,+) **NO EVAL CONDUCTED; NO ADDITIONAL $**

2. To expand the integrated services model of care to include the provision of complementary treatment to the homebound (+) **NO ADDITIONAL $**

Sub-category: Home Health: Home-based

2. Provide primary care to homebound PWA through a mobile health team (-) **NO ADDITIONAL $**

Case Management

Sub-Category: Case Management

3. To increase services for any populations which are currently underserved (-) **NO ADDITIONAL $**

Sub-category: Peer Advocate Outreach

2. Add more peer advocacy services to the integrated services models (-) **NO ADDITIONAL $**

Client Advocacy

Sub-category: **Treatment Advocacy**

2. To provide more services for newly diagnosed PWAs (+) **NO ADDITIONAL $**

4. To provide more treatment advocacy services for African American and Latino populations (+) **NO ADDITIONAL $**

5. To provide treatment focused workshops for newly diagnosed PWAs (UX) **NO ADDITIONAL $**

Food

Sub-category: **Food Bank /Meal Delivery**

2. To develop communal kitchen/cooking facilities (+) **NO ADDITIONAL $**

3. To purchase food storage facilities/refrigerators for the marginally housed/homeless (UX) **NO ADDITIONAL $**

Sub-category: **Nutritional Counseling**

1. Link nutritional counseling to treatment advocacy and primary care (including complementary therapies) (=,+) **NO ADDITIONAL $; NOT DONE**

Adoption/Foster Care

Sub-category: **Adoption/Foster Care**

1. To develop better services for adolescent placement in foster care (=,+) **NO ADDITIONAL $; NOT DONE**

Day/Respite/Childcare

Sub-category: **Adult Day Health Care**

1. To develop a program for people with moderate dementia (+) **NO ADDITIONAL $**
The following assessment needs to occur prior to the allocation of new funding: Analyze the Continuum Adult Day Health program and the St. Mary's dementia program to determine if and how they could be adapted for persons with moderate HIV related dementia.

Sub-category: **Children's Programs and Childcare**

3. To increase the reimbursement rate for childcare providers (+) **NO ADDITIONAL $**

Transportation

Sub-category: Transportation

1. To develop a dispatch system for the system-wide van pool (=,+) **NOT DONE; NO ADDITIONAL $**

4. To develop an inter-county transportation pool (+) **NO ADDITIONAL $**

5. To make available more vouchers for transportation (UX) **NO ADDITIONAL $**

Housing

Sub-Category: Housing Subsidies: Full and Shallow

2. To provide better information to those seeking housing, which includes development of a list of landlords who accept subsidies (+,UX) **NO ADDITIONAL $**

4. To create an outreach and education program for landlords and clients - landlords: special needs of PWA tenants; clients: what are their rights, how to appeal to landlords, etc. (+,UX) **NO ADDITIONAL $**

Sub-Category: Residential Hospice

1. To provide additional funds to cover increased operating costs (+) **NO ADDITIONAL $**

Sub-Category: Transitional Housing

3. To increase the availability of housing operated using harm reduction philosophies for substance users (+) **NO ADDITIONAL $;**

Sub-Category: Financial

1. To create supportive services for women and children that are linked to primary care and other necessary and appropriate services (=) **NO ADDITIONAL $**

Sub-Category: General

1. To provide COLA to housing providers to keep pace with increasing housing costs (+) **NO ADDITIONAL $**

Mental Health

Sub-Category: Long/short Term MH Services (Outpatient)

3. To provide one-time funds for operating costs for mobile teams (UX) **NO ADDITIONAL $**

7. To fund on-call, after hours psychiatric services (+) **NO ADDITIONAL $**

The following assessment needs to occur prior to the allocation of new funding: Assessment of level of need for service and assessment of type and availability of on-call, after hours services currently.

9. Increase category proportionally (+) **NO ADDITIONAL $**

Sub-Category: Psychiatric Consultation

1. To increase psychiatric assessments, with triage, at more locations, and with more linkages. Possible settings include primary care, treatment facilities, SROs, shelters, etc. (+) **NO ADDITIONAL $**

Sub-category: Crisis Services

1. Increase Services Proportionally (+) **NO ADDITIONAL $**

Sub-category: Residential Care

1. To fund/create a residential facility for PWAs with moderate dementia/cognitive impairment (+) **NO ADDITIONAL $**

Substance Abuse

Sub-Category: Residential Long-term

2. Create more services for women with families (keeping children with them) (=) (+) **NOT DONE; NO ADDITIONAL $ - INCREASED COST TO ACCOMMODATE FACILITY TO INCLUDE CHILDREN TO MEET TIGHTER LICENSURE REQUIREMENTS, ADDITIONAL STAFF REQUIRED TO ASSURE CLIENT/STAFF RATIO AND TIGHTER SCREENING OF POTENTIAL CLIENT BASE IF CHILDREN PRESENT (CRIMES OF ABUSE OR ENDANGERMENT) AS WELL AS THE NEED TO INFORM CLIENTS OF REPORTING REQUIREMENTS IF CHILD ABUSE/NEGLECT IS DETERMINED. The following assessment needs to occur prior to the allocation of new funding: Talk to appropriate current providers to determine what it would take to add beds to meet this need.**

Sub-Category: Residential Short Term

1. To redirect some funds into a residential harm reduction model (+) **NO ADDITIONAL $**

2. To evaluate the cultural appropriateness of programs and to provide training where needed (=,+,UX) **NOT DONE; NO ADDITIONAL $; TO BE ADDRESSED THROUGH SFDPH "POLICY 24" INITIATIVE**

4. Create more services for MSM/IDU'S (+) **NO ADDITIONAL $**

Sub-Category: **Out Patient Counseling**

1. Develop programs as alternatives to drug use - recreational, etc. - especially for youth (+) **NO ADDITIONAL $**

2. To develop more services for transgender PWAs (+) **NO ADDITIONAL $**
The following assessment needs to occur prior to the allocation of new funding: Talk to current providers of primary care and substance abuse services that are utilized by significant numbers of transgendered PWAs to discuss augmenting current services with outpatient counseling - assess level of need for service.

4. To create a drop-in center, which includes outpatient counseling as one of the services offered (+) **NO ADDITIONAL $**

Sub-Category: **Detox**

6. Encourage more utilization of alternative detox services, such as acupuncture (+) **NO ADDITIONAL $**

NO ACTION TAKEN

Health Care

Sub-category: **Pharmaceuticals**

1. Evaluate the need for and potential capacity to contract out a portion of non-ADAP funding to the Mental Health Section for services to persons with HIV/AIDS within the Mental Health System of Care (-,UX); **ASSESSMENT NOT DONE; CMHS CONTINUES TO PROVIDE PSYCHOTROPIC MEDICATION TO HIV+ CLIENTS IN THEIR SYSTEM**

Day/Respite/Childcare

Sub-category: **Children's Programs and Childcare**

6. To conduct an inventory of child care potential availability and need (=) **NOT DONE**

Program Support

Sub-category: REGGIE/ACE

2. To conduct an evaluation of the REGGIE project (=) **NOT DONE**

Transportation

Sub-category: Transportation

2. Conduct an evaluation of current van service providers (=) **NOT DONE**

Mental Health

Sub-Category: **Long/short Term MH Services (Outpatient)**

6. Link psychiatric case management services to Psychiatric Emergency Services (PES) (=,+) **NOT DONE; The following assessment needs to occur prior: need to determine a model for linked service; determine the number of HIV+ clients utilizing PES services and, within psychiatric case management services, how many clients are HIV+?**

NO ACTION TAKEN - UNFEASIBLE

Day/Respite/Childcare

Sub-category: **Children's Programs and Childcare**

4. To develop a voucher program for childcare services (UX) **DETERMINED UNFEASIBLE FOR ONE-TIME UNLIQUIDATED FUNDS**

Substance Abuse

Sub-Category: **Out Patient Counseling**

5. Make available child care vouchers, which can be utilized while PWAs are receiving outpatient care (UX) **VOUCHERS DETERMINED TO BE UNFEASIBLE WITH ONE-TIME UNLIQUIDATED FUNDS**

July 15, 1999

After careful deliberation, the HIV Health Services Planning Council requests that these carry-forward funds be allocated, **in descending priority order**, as follows:

1. Planning Council Support: **$129,001**

In FY 98-99 the HIV Health Services Planning Council budgeted for and began several initiatives which were not completed at the end of the fiscal year (1998-99 budgeted amount = $250,000). Use of unliquidated funds will allow these projects – the Consumer Rights Advocate position, the Client Needs Assessment, ongoing Council support, and the Grantee Assessment to be funded without disrupting plans for use of 1999-00 funds for Planning Council Support. ***Billy Pick – contract modification***

2. Reggie Project Equipment: **$140,278**

The REGGIE Project is the centralized registration and information/referral system that is being implemented among San Francisco CARE funded agencies. Funds allocated in 1998-99 were to be used for computer equipment and network connectivity and for hardware/software for bringing additional agencies into the network. Due to a longer than anticipated project timeline, all funds were not expended by the end of the fiscal year (1998-99 budgeted amount = $180,000). Use of unliquidated funds will allow this project to continue to enroll new agencies into the network during 1999-00. There are no funds allocated for this project in the 1999-00 budget. ***Billy Pick – contract modification***

3. Augmentation to the CBC Initiative: **$45,185**

The San Francisco EMA CBC initiative funds are being used to create a transitional case management program to coordinate the linkage to health care and social services for African Americans with HIV who are released from the California State Prison system to the three counties in the San Francisco EMA (1999-00 budgeted amount = $67,778). Unliquidated funds would be used to expand the target population to include Latino men, women and transgendered persons. Priority will be given in the 2000-01 budget to maintaining the program at the expanded population level. ***Billy Pick – contract modification***

4. Direct Emergency Financial Assistance: $843,268

There is currently $662,392 budgeted for this program in FY 1999-00. These funds can support approximately 1,211 unduplicated clients with $500 in direct financial assistance per client per year. An additional $843,268 in direct financial assistance will allow the contractor to support approximately 1,400 additional clients with as much as $600 per client per year. The financial assistance payments are issued to third party providers of housing related services (credit report companies, housing search companies), utilities, and medical services. ***Margo Antonetty/Walta De Lemos (Eviction Prevention & Housing Stabilization Fund - $143,268) - contract; Joseph Cecere – (Direct Emergency Financial Assistance - $700,000) - contract modification***

5. Housing: **$210,000**

All funds in this category will assist clients in stabilizing their living situations and their lives, thereby increasing their abilities to utilize the support services available to maintain their adherence to primary care regimens.

- Emergency Housing Vouchers $80,000

These funds will allow 161 clients to be housed for 28 day stays in single room occupancy (SRO) hotels (1999-00 budgeted amount = $192,233). ***Margo Antonetty - contract modification***

*• Security Deposits for rental units $100,000 ***Not approved***

These funds will assist clients moving into more stable housing. During the past several months the fair market rates have been adjusted to more accurately reflect the rental market in San Francisco. At the same time the security deposits necessary to secure this housing have also increased. Clients will be eligible to receive deposits in varying amounts for single resident occupancy hotels as well as other affordable housing options.

*• Residential Housing appliance upgrades $30,000 ***Not approved***

These funds will be used to purchase replacement refrigerators, stoves and other appliances in CARE funded residential facilities that have deteriorated through normal "wear and tear" and age.

6. Food Vouchers: **$58,030**

There is currently $58,030 available in $5 denominations for food vouchers through local grocery stores. Through the RFP process, the demand was demonstrated to be twice the amount available. The additional funds will allow for wider distribution/availability of these vouchers to clients in the community. Agencies receiving vouchers will be San Francisco Community Clinic Consortium, Shanti Project, Larkin Street Youth Center, Asian and Pacific Islander Wellness Center, and Continuum HIV Day Services - ***contract modification(s)***

7. Childcare Insurance: **$1,500**

To augment insurance coverage for the service provider to allow for provision of childcare services at major client events – workshops, meetings, retreats, etc. ***TBD***

8. Provider trainings/workshops: **$80,150**

These trainings reflect needs within the provider community identified by the HIV Health Services Planning Council, community needs assessments, and grantee program staff. ***Marshia Herring – contract development***

- Transgender Community Medical Needs $21,057

The goal of this training is to increase the awareness of providers, particularly primary care providers, of the medical and psychosocial needs of transgendered clients who are infected with HIV disease. ***Laura Thomas- coordinator***

- HIV Cognitive/Motor Complex $21,104

The goal of this training is to increase provider awareness of the cognitive/motor implications of HIV disease to assist them in making the distinctions necessary to determine the most productive interventions, whether counseling, psychopharmacological, or medical. ***David Macias- coordinator***

- Primary Care Chart Review Protocol Development $37,989

The goal of this training is to assist providers in developing instruments and protocol for chart review that would facilitate the tracking of quality of care and other evaluative measures. ***Walta De Lemos- coordinator***

9. Outreach and Program Promotion Campaigns: $60,000

Due to the number of changes in the way CARE funded services are provided to increase the access to primary care and supportive services for persons identified as unserved and underserved, there is a need to inform both clients and providers of the span of service availability. These funds would be used to coordinate the development of tools for both providers and clients to clarify the "new" system of care in San Francisco – what services are available, who provides them, how to access them. ***Marshia Herring – coordinator (workgroup)***

10. Computer Equipment/Software for Marin County: $25,803

This funding is to be used for CARE funded service providers in Marin County for the following:

15 Computers = $19,963
8 Printers = $5,840 ***Celinda Cantu - contract modification***

11. Forensic Pharmacy Services: $135,000

Funding for a 7-day supply of medication for each HIV+ incarcerated client, received upon discharge from jail. ***Joseph Cecere - contract modification***

Total amount requested to carry-forward:	$1,728,215
Amount approved	$1,598,215

PLEASE ACT NOW!!!

Colleagues:

House and Senate Labor-HHS-Education Subcommittee Appropriations conferees met last night to pre-conference the appropriation bill before it reaches the House floor for a vote. In the pre-conference, Senator Specter, who established significantly higher marks for HIV/AIDS programs in the Senate passed Labor-HHS-Ed bill, receded to the House on the HIV/AIDS accounts---cutting back the high numbers passed by the Senate to essentially the House marks. In Title I of the CARE Act the number reverted to the House mark of $525.2M ($16M cut from the Senate) and Title III reverted to $132M ($8M cut from the Senate mark). In some isolated instances the numbers are slightly above the original House marks and in some accounts like SAMHSA the mark is $45M below current spending levels.

This Labor-HHS-Ed bill will probably be attached to the DC Appropriations bill and put on the House floor for passage. Although the leadership has sweetened the bill for the President by putting more money into the education, the President is still likely to veto this bill. The delay in passage of the Labor-HHS-Ed bill means that we still have an opportunity to contact the Administration, and the House and Senate leadership and register strong opposition to these funding levels.

I know that it is difficult to find the time to make these calls but PLEASE make them and tell your friends to make them.
This is a crunch period.

Please call:

John Podesta, White House Chief of Staff (202) 456-1414

Tell the White House to support the highest possible numbers for CARE Act Title I (funding to the 51 eligible metropolitan areas), and Title III (targeted direct funding to early intervention community health centers).

Tell the White House to support the Congressional Black Caucus Minority HIV/AIDS Initiative. This initiative is currently $35M below last year's level. The initiative is critically important to urban and rural communities of color. If fully funded it would provide $26.5M additionally to Title I and 27.4M in additional resources to Title III.

Please call:

Dan Mendelsohn, Associate Director for Health and Personnel, Office of Management and Budget (OMB) 202-757-5000

Same message as above.

Please call:

Congressman John E. Porter (R-IL) (202) 225-4835

Congressman David Obey (D-WI) (202) 225-3365

Senator Arlen Specter (R-PA) (202) 224-4254

Betti-Lou Taylor, Senate Labor-HHS-Ed Appropriations Subcommittee Office (202) 224-7230 (they often have the message machine on ---leave a message)

Ellen Murray Minority Staff on Senate Labor-HHS-Ed Appropriations Subcommittee Office (202) 224-7288

Tell them that:

* You are dissapointed that they did not hold onto the increases that were acheived on the Senate side and that you expect them to regain, at a minimum, the Senate marks during the final negotiations with the Administration.
* You support full funding of the CBC Initiative to target resources to disenfranchised communities of color. This program must be increased--not flat funded or decreased. The Congress must move forward in its efforts to expand service quality and capacity to the growing number of people of color living with HIV disease.
* That you find it unconscionable that they would support a $45M cut in SAMHSA at a time when the majority of new HIV infections are related to substance abuse and there is STILL no treatment on demand in the U.S.

Ernest Hopkins
Director of Federal Affairs
San Francisco AIDS Foundation
415-487-3096

Confidentiality

All grievances and complaints will be kept confidential, if so desired by the client.

Bilingual Services

Bilingual Services are available upon request.

Non-Discrimination Policy

The ***HIV Consumer Rights Advocacy Project*** does not discriminate regardless of race, color, religion, ancestry, age, national origin, political affiliation, creed, domestic partnership status, marital status, sex, sexual orientation, gender identity, disability or HIV/AIDS status.

HIV Consumer Rights Advocacy Project
1540 Market Street, Suite 301
San Francisco, CA 94102

HIV Consumer Rights Advocacy Project

Providing mediation and advocacy for people living with HIV/AIDS in San Francisco.

1540 Market Street, Suite 301
San Francisco, CA 94102
(415) 863-8131

Our Mission

Our mission is to assist clients in resolving the barriers which prevent access to designated HIV services in San Francisco. In so doing, we strive to insure all clients receive appropriate and satisfactory HIV services in San Francisco through a comprehensive review of all grievances in a safe and HIV/AIDS sensitive environment.

The HIV Consumer Rights Advocacy Project is a Project of the PWA Caucus of the HIV Health Services Planning Council (CARE Council) pursuant to the Ryan White CARE Act.

Our Goals

- Assist clients in filing grievances and complaints with HIV/AIDS service providers.
- Assist clients in mediating their grievances with HIV/AIDS service providers.
- Assist clients in advocating their claims with HIV/AIDS service providers.
- Provide information and make referrals concerning available HIV/AIDS services in San Francisco.

HIV Consumer Rights Advocacy Project
1540 Market Street, Suite 301
San Francisco, CA 94102
Phone: (415) 863-8131
Fax: (415) 863-0831

How we can help *You*

3 Steps to Service...

1. Complete the agency's internal grievance process.*
2. If you are dissatisfied with the agency's decision regarding your grievance, contact the *HIV Consumer Rights Advocacy Project* for a telephone or in-person appointment.
3. Complete an in-take form with the *HIV Consumer Rights Advocate* in order to assess the nature of your complaint and what reasonable steps are necessary to resolve your claim.

* If you are unable to fill out the agency's grievance form, contact the *HIV Consumer Rights Advocacy Project* for assistance.

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

November 22, 1999
AGENDA

I.	Call to order	4:30 PM
II.	Roll Call	4:32 PM
III.	Review and Approval of Agenda	4:35 PM
IV.	Review and Approval of Minutes, 10/25 & Attachment A of 8/23 — **VOTE**	4:37 PM
V.	General Announcements	4:45 PM
VI.	Public Comment	4:55 PM
VII.	Reports	
	• Mayor's Liaison - Bill Barnes	5:00 PM
	• Steering Committee Tony Leone Council Support Coordinator Position Update—November 30 reception Treatment on Demand Planning Council—Integration Dollars	5:10 PM
	• Implementation & Evaluation Committee Implementation Document for 2000-01 — **VOTE** Decreased Funding Scenarios — **VOTE**	5:20 PM
Break		6:00 PM
	• Implementation & Evaluation Committee, Cont'd Unallocated Funding Priorities — **VOTE**	6:15 PM
	• AIDS Office	6:25 PM
	• Grantee Assessment Task Force	6:35 PM
	• Housing Committee HOPWA Appointee — **VOTE**	6:45 PM
	• PWA Caucus	6:55 PM
	• Membership Committee	7:05 PM
	• Western Region Planning Councils	7:15 PM
VIII.	New Business	7:25 PM
IX.	Adjourn	7:30 PM

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Upcoming meetings:

Day	Date	Type	Location	Time
Mon	11/29	Membership Committee	25 Van Ness, Rm. 330-A	5:30 - 7:00 PM
Wed	12/1	Housing Committee	25 Van Ness, Rm. 330-B	3:00 - 5:00 PM
Mon	12/6	Steering Committee	25 Van Ness, 5th Fl Conf Rm	5:00 - 7:00 PM
Tues	12/7	Implementation & Evaluation Committee	25 Van Ness, Rm. 330-B	5:00 - 7:00 PM
Wed	12/8	PWA Caucus	25 Van Ness, Rm 330-B	5:30 - 7:00 PM
Mon	12/13	HIV Health Services Planning Council	City Hall, Room 201	4:30 - 7:30 PM

San Francisco Department of Public Health, AIDS Office, 25 Van Ness Avenue, 5th floor
HIV Health Services Planning Council, 1540 Market Street #301, San Francisco, CA 94102

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HIV HEALTH SERVICES PLANNING COUNCIL

November 22, 1999

The Minutes of this meeting are missing.

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HIV Health Services Planning Council

HIV Health Services Planning Council

City Hall, Room 201, 1 Dr. Carlton B. Goodlett Place

December 13, 1999

December 13, 1999

AGENDA

agenda

Fire - total accounting for vouchers in

I.	Call to order	4:30 PM
II.	Roll Call	4:32 PM
III.	Review and Approval of Agenda	4:35 PM
IV.	Review and Approval of Minutes, 11/22 — VOTE	4:37 PM
V.	General Announcements	4:45 PM
VI.	Public Comment	4:55 PM
	• Letter of Support for UARP Research ← Did you get it ?	
	• Resolution Endorsement Request re: Tenderloin Parolees	
VII.	Reports	
✓	• Mayor's Liaison - Bill Barnes	5:00 PM
	• *Steering Committee*	5:10 PM
	✓ Discussion—REGGIE—Next Steps (Not Counties)	
	✓ Joint Planning Councils Meeting	
	✓ Council Support Coordinator Position – Update	
	✓ Needs Assessment Supplement – Next Steps – Harder & Company	
	✓ Quality of Care Task Force	
✓	• *Implementation & Evaluation Committee*	5:30 PM
✓ →	Reduction Protocol Scenarios — VOTE passed	
✓	Unallocated Funding Priorities — VOTE passed	
Break		6:00 PM
✓	• *Grantee Assessment Task Force* : check Jan 6 Thurs. 4:00 - 5:00	6:15 PM
	• *Housing Committee*	6:30 PM
	• *PWA Caucus* : Feb ≠ Mission Forum	6:45 PM
	• *Membership Committee*	7:00 PM
VIII.	New Business	7:25 PM
IX.	Adjourn	7:30 PM

M — May
Ju — Jun
Se — Nov
De - Feb

Upcoming meetings:

MSMTDU

Upcoming meetings:

Day	Date	Type	Location	Time
Mon	12/20	Quality of Care Task Force	25 Van Ness, 5th Fl. Conf. Rm.	1:00 – 2:30 PM
Mon	1/3	Implementation & Evaluation Committee	25 Van Ness, Room 330A	5:00 – 7:00 PM
Wed	1/5	Housing Committee	25 Van Ness, Room 330A	3:00 – 5:00 PM
Wed	1/5	PWA Caucus	25 Van Ness, Room 330B	5:30 – 7:30 PM
Thurs	1/6	Membership Committee	25 Van Ness, Room 330A	5:30 – 7:30 PM
Mon	1/10	Steering Committee	25 Van Ness, 5th Fl. Conf. Rm.	5:00 – 7:00 PM
Mon	1/24	HIV Health Services Planning Council	City Hall, Room 201	4:30 – 7:30 PM

150
20
170
10
180
38
218
2
220.8

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SF

HIV Health Services Planning Council
Minutes, December 13, 1999

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I. Call To Order
4:30 PM

II. Roll Call
Attachment A, Column 1. A quorum of the membership was present.

III. Review and Approval of Agenda
Agenda approved.

IV. Review and Approval of Minutes (VOTE)
EW motioned for approval of the 11/22 minutes be held until the January Council meeting since many members hadn't had time to review the Council package. Motion was carried.

V. General Announcements
NN clarified his status on the Council. He has submitted his resignation, but he suggested that it not take effect until his replacement can be appointed. He said he anticipated that the Director of Public Health would be submitting a nomination by early January.

VI. Public Comments

- *Laura T.* requested an endorsement by the Council for a letter of support regarding UARP Research. The research will evaluate case management of Title 1 Ryan White dollars. The Co-Chairs will sign for the Council an endorsement letter.
- *SS* reported that at the November Council meeting members were asked to endorse a resolution supporting HIV positive parolees return to the Tenderloin that are currently restricted to do so as a condition of parole. *SJ* gave further information regarding the current policy and problem. (See Attachment B)
- *EW* announced the All Title Conference in DC on 01/18-22/00. This year attendees will be one (1) grantee representative, one (1) Council co-chair representative, and one (1) consumer representative from the Council. *MDL* will be attending as the grantee person; *SJ* will be attending as co-chair. The Council consumer has yet to be chosen, names are to be forwarded to *EW* for consideration. The criteria for considerations will be Council and Council Committee meeting attendance over the last two quarters of 1999.
- *Paul K.*, Executive Director of the Tenderloin AIDS Resource Center, thanked the co-chairs for meeting with the contractors. He spoke in opposition of the REGGIE system due to administrative failures. *Nathan*, SFAF, spoke in favor of the REGGIE system. *Hosea*, Shanti Project, came to request funds from the Council to replace older vehicles.

VII. Reports

Mayor's Liaison Report

- *Bill Barnes*, Mayor's Office liaison, reported on the HIV surveillance policy from the CDC getting states to start implementing a surveillance system. He reported that SP-1029 bill from *Senator Haines* that requires HIV name reporting will be heard in January in Sacramento. *BB* stated in favor of REGGIE.
- *SS* introduced the discussion regarding appointments/re-appointments of Council members by the Mayor. There are concerns about inconsistencies in the criteria of re-appointments. *SS* requested that *BB* be present at the next Membership meeting to review process of appointment/re-appointment with Membership Committee members. She stated that the inconsistency affects the efficient functioning of the CARE Council.

Steering Committee Report

- *Dr. Mitch Katz*, Director of SFDPH, addressed the CARE Council regarding REGGIE. *MK* gave an historical perspective on REGGIE and its current situation. *MK* presented REGGIE system contractors documentation. (Attachment B). *MK* is looking for community consensus on REGGIE, is it a benefit or not to the HIV community. It should be assessed by (1) the historical reasons to keep clients from not

having to reregister with all the agencies they receive services from, (2) to provide HRSA with unduplicated data and (3) to have evaluation survey data available.

- *SS* reported that a REGGIE Task Force can be reformed to provide a forum for Council response and to make an assessment between now and 1/15/00 of REGGIE and let DPH know the Council's will. The Task Force will be under I&EC, both co-chairs of I&E Committee are willing to reform the task force. Though this will be a time sensitive task force, *SS* recommended that the task force findings be presented for a vote during the 1/24/00 Council meeting. *SS* recommended that interested persons speak with *GG* and that the first meeting start on 1/10/00. Due to the short time the initial meeting will look at how to increase consumers and contractors' involvement in the REGGIE Task Force. (See Attachment C)
- *Michael DeMayo*, Harder & Co. Associate Research, reported on the Needs Assessment and Client Level Surveys. Part Two of the surveys will focus on five undersampled populations using the original tools from the first survey only in San Francisco. Those undersampled populations are to be Latinos, API, youths (under 25) and MSM IDUs. An additional 350 surveys are to be collected and added to the 958 surveys already done. Hiring interviewers has been started; in addition, HAR is looking to hire HIV-positive Spanish-speaking interviewers. Interviewers will be paid by the hour. Participants will be paid cash to complete survey.
- *SS* reported on the Joint Planning Councils meetings. These meetings to see if there were a "will and a way" to address concerns of cross disciplines coordination of services needs from the HIV infected/affected communities. The groups involved includes, the CARE Council, Treatment On Demand, HPBC, Maternal/Child, Mental Health Advisory Board.
- *SS* reported on the Quality of Care Task Force that met on the heels of the Needs Assessment to address client satisfaction and the quality of care of the system items, in general, that the Needs Assessment missed. This task force will look at the next step at for client satisfaction tools. It is looking into standardizing the client satisfaction tools that are currently in use, here and nationally, as a first step. *MJW* cautioned on potentially creating a greater burden on agencies with tools in place and gave another county's example.
- *SJ* spoke to the City Attorney regarding the Staff Coordinator's position that *EW* as taken. The City Attorney suggested a reading of government code 10.90. The Co-chair's went into the by-laws and saw that there is not a mechanism is in place. It will be referred to the By-Law Task Force of the Membership Committee. *MJW* reported that up until about the last two years, the Planning Council Support had always been provided by the AIDS Office. Two years ago the Planning Council decided that it wanted to contract this support out. She rhetorically asks that why doesn't the Council approach the AIDS Office and re-establish logical support through them. While identifying good support, she felt it has been inconsistent and usually ad hoc and emergency basis. She asks that the Planning Council look into this process. Both *SJ* and *SS* both agreed with *MJW*'s assessment and are looking into the process to stabilize Council Staff Support.

Grantee Assessment Report

AM reported that he has been given a list of errors from the AIDS Office and has forwarded this list to the consultant. He hoped that the error list can be reviewed and corrections incorporated into the GA document. If she has any concerns or dispute there will be a meeting between the GATF, the consultant and the AIDS Office to resolve any issues. The goal will be to package the revised final report with the AIDS Office Response as a companion document. *AM* reported that at the 1/00 Council meeting, the GA consultant formal presentation with the AIDS Office Response presentation and look at implementing recommendations or prioritizing the next steps.

Implementation & Evaluation Report

- *SO* spoke about the two items up for Council vote: (1) Reduction Protocol Scenarios (RPS) and (2) Unallocated Funding Priorities (UFP). RPS will be used when the city receives its awards. It is a based on 2% reduction assumptions to prepare for the award. There are few changes, at the second level reduction - Housing and Planning Council Support will be held harmless, and there is some new language in the revised draft of the RPS. This revised draft is up for vote. (See Attachment D). A budget has been

prepared for the upcoming fiscal year for Council Support and Council initiatives (e.g., Grantee Assessment and the Needs Assessment). It will be presented to the Planning Council in January's meeting. *GG* called to question, 1 - Abstain, 0 – No, for call to question. Roll Call VOTE: 7 – Abstain, 14 – Yes, 0 – No. (See Attachment A, Column 2).

- *SO* spoke about the UFP. He reported that there were two processes, (1) those dollars to be spent between 12/99 - 2/29/00 and (2) those funds identified after 2/00. The UFPs voted upon were those that identified in 10/99 that are out of contract for a variety of reasons. I&EC went through recommendations from sub-committees and revised UFP. *MDL* reported that under Food Vouchers the amount should be $50,000. *SO* reported that under Mental Health Assessment the estimated $20,000 for benefit enrollment, the AIDS Office reports that their research reveals that there are now no waiting lists, thus releasing this amount to UFP. There was discussion on the prioritization of transportation funding. *SS* presented a motion to take the $20,000 to maintenance of buildings, potentially benefiting 200 – 300 HIV positive clients, and add it to Section D from Section A. Several members from Council and the public agreed with the motion. Roll Call VOTE: 5 – Abstain, 19 – Yes, 0 – No. (see Attachment A, column 3). Updates to UFP, in Section A $150,000 increases to $170,000 and Section G is corrected to $50,000. On the UFP with Council updates, Roll Call VOTE: 19 – Yes, 1 – Abstain. See Attachment A, Column 4).
- *SS* stated that the current process and timing of the "UN"-Funds is imperfect. She cites reports of contractors asking about one-time only funding with the implication that some contractors are hearing about potential available monies that others are not making the process unfair. She stated that funding programming other than food and transportation vouchers could be possible when process is attended better.

Membership Committee Report

- *EW* reported that approximately 10 seats are open. He reports that the candidates' names will be forwarded to Council in January. Potential candidates have been invited to the next Membership Committee meeting to find out about Council's commitments and responsibility. He reports that the Council stands in compliance with its membership by-laws - 50/50 HIV positive (disclosed) to HIV negative persons, the names currently in consideration would take the Council out of compliance. A majority of the current candidates are HIV negative. He is hoping in January there will be a balance of names.
- *EW* introduced *CG* as a new Council member who represents the Title IV seat.
- There was a discussion about individual appointments to Council that have been left "in limbo" by the Mayor's Office.

PWA Caucus Report

- *EW* reported that there would be a couple of upcoming forums. The Mission Forum is in February. He stated that the volunteers for this forum are *LG*, *LDT*, *SO*, *RC*, *JM*, *NR* and requests that these members be present at the next PWAC to set date and assignments for the forum. He stated that he wants members to know that this is not an exclusive list and invited others to help with the forum. The next PWAC meeting is Wednesday, 1/5/00, 5:30 PM – 7:30 PM.
- The Castro Forum is tentatively set for late February or in March.
- *EW* reported in September, the Council voted on a process to pay a stipend of $50 a month to Council members with HIV who are eligible for CARE-funded services, for attendance at Council meetings as well as helping Council members with child care expenses. The PWAC will draw up a procedure draft to address this process and present this procedure document at the 1/00 Council meeting.

Housing Committee Report

AR reported that at the next Housing Committee meeting there would be a report back regarding Eviction Prevention, a new program, and that there will be a presentation from the Consumer Advocate. She asks that members come to the Housing Committee meeting.

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VIII. **New Business**

No new business discussed.